AUSTRALIAN DOMESTIC AND FAMILY VIOLENCE DEATH REVIEW NETWORK

2018



Data Report

NSW GOVERNMENT

QUEENSLAND COURTS

Government of South Australia
Office for Women

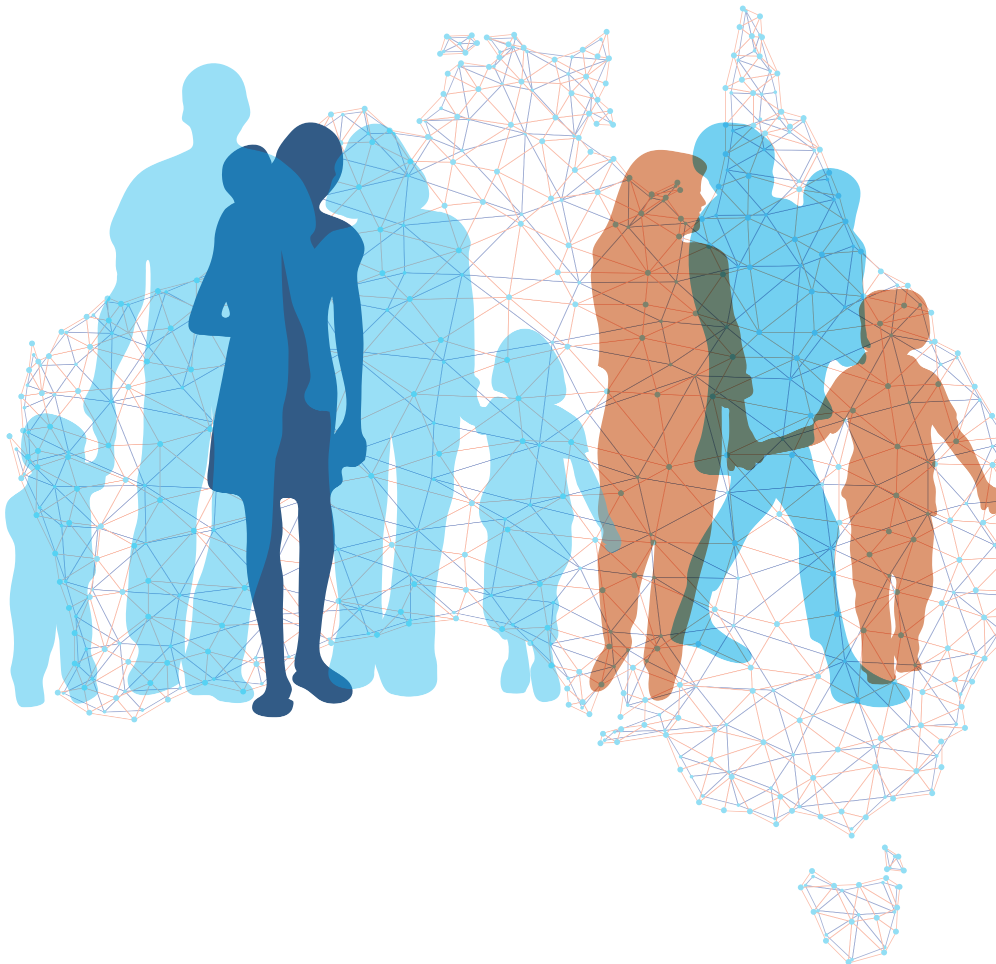
MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION

Coroners Court of Victoria

Ombudsman Western Australia
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NORTHERN TERRITORY OF AUSTRALIA
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Data Report 2018

May 2018

A report of the Australian Domestic and Family Violence Death Review Network

The views expressed in this report do not necessarily reflect the private or professional views of individual Network members or the views of their individual organisations.

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Disclaimer

While this publication has been formulated with due care, the Australian Domestic and Family Violence Death Review Network does not warrant or represent that it is free from errors or omissions, or that it is exhaustive.

Readers are responsible for making their own assessment of this publication and should verify all relevant representations, statements and information with their own professional advisers.



The Australian Domestic and Family Violence Death Review Network acknowledges the traditional owners of the land on which we work and live.

We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and emerging; and recognise the strength and resilience of Aboriginal people in this land.

FOREWORD

As the current Chairperson of the Australian Domestic and Family Violence Death Review Network ('the Network'), I have the privilege of introducing the *Australian Domestic and Family Violence Death Review Network Data Report 2018,* which provides data on intimate partner homicides that have occurred across Australia between 2010 and 2014.

Analysis of this data can provide a better understanding of potential opportunities for intervention prior to domestic and family violence related homicide, and inform prevention initiatives at a national level.

The development of this specialised national domestic and family violence homicide dataset has been one of the key goals of the Network since its establishment and is the culmination of years of extensive work and collaboration.

This has included the Network:

- Establishing a nationally standardised definition of a 'domestic and family violence related homicide' as outlined in the Network's Homicide Consensus statement;
- Developing Data Collection Protocols that outline the agreed minimum data collection requirements and establish a coding system; and
- Establishing Data Sharing Protocols that provide the necessary governance arrangements to allow for cross-jurisdictional data sharing.

This report demonstrates the Network's unique ability to establish and maintain a national dataset of domestic and family violence deaths. Whilst this initial report is limited to intimate partner violence related homicides, the National Data Sharing Protocols allow for the development of a staged and standardised national dataset of domestic and family violence related deaths. It is anticipated that the Network will ultimately extend its data collection to include homicides within a family relationship, 'bystander' homicides[1], and suicides that have been identified as domestic and family violence related.

It is important as both the current Chair, and a member of the Network, that I also acknowledge members' contribution over the past seven years on a range of other projects in addition to the work profiled in this report.

Since its establishment, the Network has:

- Established shared principles of effective domestic and family violence review processes to guide implementation in all jurisdictions;
- Provided ongoing support to jurisdictions during scoping and establishment of their respective death review processes;

1 For instance, a person who is killed intervening in a domestic and family violence episode.



- Contributed to peer-reviewed publications detailing the Australian domestic and family violence death review landscape in both the Homicide Studies[2] journal and in the book Domestic Homicides and Death Reviews: An International Perspective;[3]
- Contributed to international forums on domestic and family homicides, most notably the 2017 International Domestic Violence Death Review Committee roundtable, co-hosted by the University of Guelph and Griffith University; and
- Prepared submissions to the Australian Human Rights Commission concerning the development of domestic and family violence death review mechanisms nationally.

The Network is also piloting a process by which to collate and monitor recommendations informed by domestic and family death review processes across jurisdictions. We hope to report on of the findings of this process in the near future.

The Network operates under a consensus decision making model and I would like to acknowledge the capacity and willingness of all members to collaborate on projects; to collectively develop nationally robust and consistent principles to guide state-based activities; and support each other in the day-to-day work of systematically reviewing domestic and family violence deaths. This work is both challenging and rewarding but would be far more difficult without the collegiate collaboration and support of other Network members.

In particular, the Network would like to thank both Anna Butler and Emma Buxton-Namisnyk, from the New South Wales Domestic Violence Death Review Team Secretariat, for their extensive work in compiling and analysing the data and producing this report.

This report would also not have been possible without the sustained commitment of the State and Chief Coroners in each jurisdiction, and the Western Australian Ombudsman. Without their ongoing endorsement of this work, developing a national picture of domestic and family violence homicides would not have been possible and on behalf of the Network, I extend our gratitude for their ongoing leadership in this area.

Domestic and family violence deaths are tragic and, as shown by death review mechanisms both in Australia and internationally, can be considered preventable deaths. While it is an honour to bring a greater voice to those who have lost their lives to domestic and family violence, our sympathies extend to the families and friends left behind, forever changed by their loss.

Heidi Ehrat

Senior Research Officer (Domestic Violence) Coroner’s Court South Australia
Australian Domestic and Family Violence Death Review Network Chair (2018)

2 L. Bugeja et al, ‘The implementation of Domestic Violence Death Reviews in Australia’ (2013) 17 (4) *Homicide Studies* 353, 64.

3 A. Butler et al, ‘Australia’ in M. Dawson (ed), *Domestic Homicides and Death Review: An International Perspective* (Palgrave Macmillan, London, 2017) 125-158.

HELP & SUPPORT

Readers seeking support or information in relation to domestic or family violence can contact the National Sexual Assault, Domestic Family Violence Counselling Service on **1800 RESPECT (1800 737 732)**.

Readers seeking support and information about suicide prevention can contact **Lifeline on 13 11 14** or the **Suicide Call Back Service 1300 659 467**.

Guidelines for safe reporting in relation to suicide and mental illness for journalists are available at: **http://www.mindframe-media.info/for-media/media-resources.**



CONTENTS

TERMS & ABBREVIATIONS

Terms

Abuser: A person who uses domestic and family violence behaviours against a victim.

Country of birth: Designates the country a person was born in. A person's country of birth may not reflect a person's ethnicity or ethnic background.

Cross-Domestic Violence Order: A Domestic Violence Order where both parties are named as protected persons and respondents in the order (see *Domestic Violence Order*).

Disability pension: A financial support allowance provided to a person with a physical, intellectual or psychiatric condition that stops them from working.

Retired/pension: A person who receives an age pension in circumstances where they are no longer working, or a person who is otherwise retired and no longer working in a paid capacity.

Domestic and family violence: Domestic and family violence is a complex phenomenon that encompasses a pattern of behaviour whereby one person intentionally and systematically uses violence and abuse to gain and maintain power over another person with whom they share an intimate or familial relationship. Abusive behaviours may be physical, sexual, verbal, social, economic, psychological, emotional, and spiritual. Abusive behaviours can be direct or indirect, actual or threatened.

Domestic Violence Order: A civil order which protects a person from another person who they are, or have been in an intimate or familial relationship with. The order is designed to protect the protected person from further risk of violence. The term includes provisional, interim and final orders.

Domestic violence victim: A person who has domestic and family violence behaviours used against them.

Economic abuse: A spectrum of abusive behaviours related to a partner or family member's access to economic resources (including limiting access to finances, access to work etc). This behaviour is intended by an abuser to diminish a victim's ability to support him/herself and forces him/her to depend on the abuser financially.

Emotional abuse: A broad spectrum of behaviours employed by abusers in order to frighten, belittle, humiliate, unsettle and undermine a victim's sense of self-worth. This can include verbally denigrating the victim; making threats regarding custody of children as a means to control the victim; blaming the victim for all adverse events; fabricating or exploiting a victim's mental illness; and deliberately creating dependence (see *Psychological abuse*).

Family law proceedings: Proceedings commenced in the Family Court of Australia or in the Federal Magistrates' Court (all states except for Western Australia). In Western Australia, proceedings commenced in the Family Court of Western Australia.

Gender: The term 'gender' is used in this report to indicate people's gender identity notwithstanding their biological sex classification. It is acknowledged that peoples' biological sex may differ from their gender identity. This term also more comprehensively reflects the gendered nature of domestic and family violence; related to the socially constructed classifications and characteristics attributed in particular to male and female sex categorisations.

Homicide offender: The person who's actions inflicted the injuries to the homicide victim that caused their death/homicide.

Homicide victim: The person who died because of the injuries inflicted by the homicide offender.

Intimate Partner Violence: A pattern of behaviour whereby one person intentionally and systematically uses violence and abuse to gain and maintain power over another person with whom they share, or have previously shared, an intimate relationship (see *Domestic and Family Violence*).



Mechanism of homicide: The manner by which a person perpetrates a fatal assault against another person, or the way in which one person kills another person. Can include methods such as assault with a sharp weapon, or assault with a blunt weapon.

Physical violence: Any assault on the body without a weapon such as shaking, slapping, pushing, spitting, punching, non-lethal strangulation, kicking or pulling hair. Physical violence also includes any assault on the body using a weapon.

Primary DV abuser: The person who primarily initiated domestic violence in the life of the relationship and/or was the main aggressor of domestic violence after the relationship had ended. This term is designed to highlight that a person may have been the primary user of domestic violence prior to the homicide, and the homicide may have been perpetrated by a person who was typically a victim of domestic violence (for instance, a victim who kills an abuser in self-defence).

Primary DV victim: The person who primarily had domestic violence used against them (was victimised) during the relationship with an abuser, or after that relationship had ended. The term designates a person who experienced, but did not initiate domestic violence. This term is designed to highlight that a person may be the primary victim of domestic violence prior to the homicide, but may ultimately perpetrate the homicide (for instance, a domestic violence victim who kills an abuser in self-defence).

Protected person: The person who is named as the protected person under an existing Domestic Violence Order (see *Domestic Violence Order*).

Psychological abuse: A broad spectrum of behaviours employed by abusers in order to frighten, belittle, humiliate, unsettle and undermine a victim's sense of self-worth. This can include verbally denigrating the victim; making threats regarding custody of children as a means to control the victim; blaming the victim for all adverse events; fabricating or exploiting a victim's mental illness; and deliberately creating dependence (see *Emotional abuse*).

Residence: An owned or rented premises where a person resides. Includes social housing residences, boarding, or other accommodation where a person lives.

Respondent: The person who is restrained by the existing Domestic Violence Order (see *Domestic Violence Order*).

Sexual abuse: Unwanted or non-consensual sexual behaviours used by an abuser against a victim.

Spiritual abuse: A range of abusive behaviours used by an abuser against a victim under the guise of religion, including harassment or humiliation, which may result in psychological trauma. Behaviours may include an abuser denying a victim's spiritual or religious beliefs and practices in an attempt to control and dominate them.

Social abuse: A range of abusive behaviours designed to prevent a person from spending time with family and friends, and participating in social activities. Socially abusive behaviours often isolate victims, allowing abusers to maintain control over them.

Stalking: A range of tactics whereby an abuser intentionally and persistently pursues a victim in order to control or intimidate that victim or seek to make the victim fearful. Stalking behaviours can include the abuser following the victim, loitering near the victim's home or work, and breaking into the victim's house. Stalking also includes acts of technology facilitated abuse such as persistent text messaging, maintaining surveillance over the victim's phone or email; covertly recording the victim's activities; and engaging with the victim on social media/dating sites under a false identity. Stalking can occur both during an intimate relationship, or after a relationship has ended

Substance: A pharmacological or non-therapeutic drug used for non-medical purposes. Substances may include illicit drugs or other non-illicit substances that are being used in ways contrary to their intended medical or other purpose.

Unemployed: Not engaged in routine paid work, including home duties.

Verbal abuse: A range of abusive behaviours used by an abuser to belittle or denigrate a victim (see *Psychological abuse, Emotional abuse*).

Workplace: The place a person ordinarily works as part of routine paid, or unpaid, employment.

Abbreviations

IP: Intimate Partner

IPV: Intimate Partner Violence

IPV homicide: Intimate Partner Violence homicide

DFV: Domestic and Family Violence

DFV death review mechanisms: Domestic and Family Violence Death Review Mechanisms

Primary DV abuser: Primary Domestic Violence abuser

Primary DV victim: Primary Domestic Violence victim



FIGURES

EXECUTIVE SUMMARY

The Australian Domestic and Family Violence Death Review Network ('the Network') was established in 2011 and represents a unique collaboration between domestic and family violence death review mechanisms across Australia. Network members have specialist expertise in domestic and family violence related issues and access to extensive information pertaining to domestic and family violence deaths. This is critical to providing a more informed, holistic understanding of the circumstances and context of a domestic and family violence related death.

In recent years the Network has undertaken extensive work to develop a National Minimum Dataset of domestic and family violence related deaths and this report presents key findings from this specialised dataset.

This report demonstrates the breadth of information and data that is held by the Network, and its unique ability to collect and report on data in relation to domestic and family violence related deaths.

Key data findings

Overview

- Between 1 July 2010 and 30 June 2014 there were 152 intimate partner homicides in Australia which followed an identifiable history of domestic violence (including a reported and/or anecdotal history of violence) ('IPV homicides').

- The majority of these IPV homicides involved a male killing their female (current or former) intimate partner (n=121, 79.6%), and the majority of those males who killed a female had been the primary abuser against that female prior to her death (n=112, 92.6%).

- Fewer IPV homicides involved a female killing her male (current or former) intimate partner (n=28, 18.4% of all IPV homicides), and of these cases, most of the female homicide offenders were primary victims of violence who killed a male abuser (n=17, 60.7% of female perpetrated IPV homicides).

Males who killed female intimate partners

- Most males killed their current female partners (n=77, 63.6%), and fewer killed former female partners (n=44, 36.4%).

- Almost half of the males who killed a former female partner killed that partner within three months of the relationship ending (n=21, 47.7%).

- Almost a quarter of males who killed their current or former female partners were named as respondents in Domestic Violence Orders protecting the female homicide victim at the time of the death (n=29, 24.0%).

- Almost half of all males who killed a female partner were using alcohol at the time of the homicide (n=59, 48.8%).

- The most common outcome for males who killed their female intimate partners was a murder conviction (n=58, 47.9%). Over 20% of males who killed a female intimate partner died by suicide after the homicide (n=26, 21.5%).

- Almost 20% of males who killed a female intimate partner identified as Aboriginal (n=24, 19.8%). The multi-stratum reasons for this overrepresentation are not examined in this report and caution must be used in interpreting this data finding. This data should be read in conjunction with other literature examining Aboriginal and Torres Strait islander family violence in Australia.



Females who killed male intimate partners

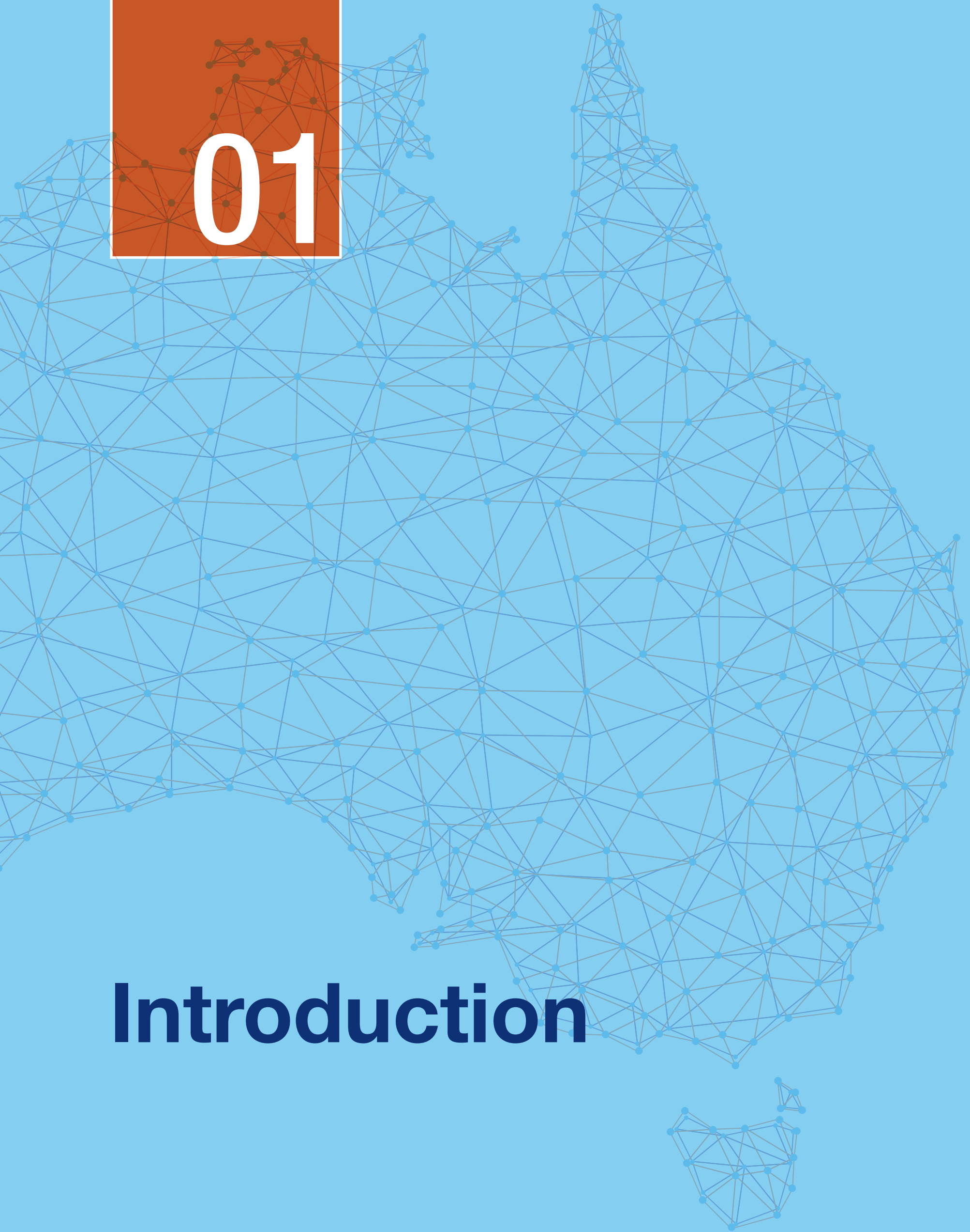
- Most females killed a male partner they were currently in a relationship with (n=23, 82.1%), and of the five females who killed former partners, two killed that partner in a period longer than three months after separation.
- A quarter of females who killed their current or former male intimate partners were protected under Domestic Violence Orders naming the male homicide victim as the respondent at the time of the homicide (n=7, 25.0%). Four males were named as protected persons under Domestic Violence Orders naming the female homicide offender as the respondent (14.3%). In one case the male victim was protected and named as a respondent under a cross-Domestic Violence Order.
- Half of the females who killed males were using alcohol at the time of the fatal episode (n=14, 50.0%).
- The most common outcome for females who killed a male partner was a manslaughter conviction (n=20, 71.4%).
- One female died by suicide after killing her male partner.
- Almost half of the female homicide offenders identified as Aboriginal (n=13, 46.4%). The complex factors shaping Aboriginal and Torres Strait Islander women's experiences of domestic violence and uses of violence are not considered in this report, and caution should be adopted in interpreting this data. Again, this data should be read in conjunction with other literature examining Aboriginal and Torres Strait Islander family violence in Australia.

IPV homicide and children

- In this dataset two children were killed in addition to their mother in a homicide perpetrated by her male intimate partner.
- Of the 152 homicide events examined in this dataset, there were at least 107 children under the age of 18 who survived the intimate partner homicide involving one, or both, of their parents.

Histories of domestic violence behaviours preceding homicides

- Detailed information was available in relation to IPV homicides and histories of violence in New South Wales, Victoria, Queensland, South Australia and the Northern Territory. Analysis of this detailed information resulted in a 'focused dataset' which examined the behaviours Primary DV abusers used prior to the homicide.
- The 'focused dataset' comprised 105 cases where male Primary DV abusers killed female victims, two cases where female Primary DV abusers killed male victims and two cases where male Primary DV abusers killed male victims.
- Of the 105 cases in which a male Primary DV abuser killed a female victim, most males had previously used physical violence against the female they killed (n=80, 76.2%); most had previously used emotional or psychological violence against the female they killed (n= 84, 80.0%); over half had been socially abusive towards the female victim (n=64, 61.0%); and fewer were known to be sexually abusive towards the victim (n=13, 12.4%).
- Over a third of male Primary DV abusers who killed a female homicide victim had stalked the victim either during the relationship or after it had ended (n=38, 36.2%).



01

Introduction



Domestic and Family Violence Deaths

Domestic and family violence is a complex phenomenon that encompasses a pattern of behaviour whereby one person intentionally and systematically uses violence and abuse to gain and maintain power over another person with whom they share, or have shared, an intimate or familial relationship. Abusive behaviours may be physical, sexual, verbal, social, economic, psychological, emotional, and spiritual. Abusive behaviours can be direct or indirect, actual or threatened.

Domestic and family violence has a devastating impact on individuals and communities. It can occur within a range of familial or family like relationships and includes: child abuse; violence between siblings; violence by adolescents against parents; elder abuse; carer abuse; violence between same-sex partners; and violence perpetrated by women against their male intimate partners. However, in the overwhelming majority of cases, domestic and family violence is perpetrated by males against their female intimate partners.

Domestic and family violence can also be fatal. A significant proportion of all homicide victims are killed by a person with whom they share or have shared a domestic relationship, that is, a current or former intimate partner or family member. Women are significantly over represented in this category of homicide.

Domestic and family violence deaths rarely occur without warning. In many fatal cases, there have been repeated episodes of abuse prior to the homicide, as well as identifiable risk indicators. There have typically also been potential missed opportunities for individuals or agencies to intervene before the death. When viewed as the escalation of a predictable pattern of behaviour, domestic and family violence deaths can be seen as largely preventable.

The Domestic and Family Violence Death Review Network

Domestic and family violence death review mechanisms

By the mid-2000s there was a national call for the establishment of domestic and family violence death review processes in Australia. Within the past nine years, Victoria, Queensland, New South Wales, South Australia, Western Australia and the Northern Territory have each implemented a permanent domestic and family violence death review function with dedicated resources. In 2015 a 12 month pilot death review process was commenced in the Australian Capital Territory; and Tasmania is currently undertaking scoping work to consider jurisdictional capacity to implement a domestic and family violence death review process.

The broad objective of these reviews is to identify limitations and potential areas for improvement in systemic responses to domestic and family violence. Domestic and family violence death reviews operate with a view to identifying patterns and commonalities between deaths for the purposes of reform. Such processes are effective in identifying and addressing weaknesses in service delivery and systems related to domestic and family violence.

These reviews also provide a unique opportunity to collect and analyse data on domestic and family violence deaths in each jurisdiction. A summary of the different approaches and models of review currently operating in Australia can be found in the Network's Terms of Reference at **Appendix A.**

Establishment of the Australian Domestic and Family Violence Death Review Network

Following the implementation of domestic and family violence death review mechanisms across several Australian jurisdictions in recent years, in March 2011 the Australian Domestic and Family Violence Death Review Network ('the Network') was established.

The establishment of the Network aligns with Strategy 5.2 of the national policy agenda as detailed in *Time for Action: The National Plan to Reduce Violence Against Women and their Children (2010 – 2022)* ('the National Plan').

This mandates that states and territories work together to:

Drive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence.[1]

Network membership

The Network comprises of permanent representatives from each of the established Australian domestic and family violence death review teams, namely:

- Victorian Systemic Review of Family Violence Deaths (Vic);
- Domestic Violence Death Review Team (NSW);
- Domestic and Family Violence Death Review Unit (Qld);
- Domestic Violence Unit (SA);
- Reviews Team (WA); and
- Family Violence Death Review Unit (NT).

The Network recognises that Tasmania and the Australian Capital Territory are exploring, or trialling, the implementation of death review mechanisms within their jurisdictions. Representatives of these jurisdictions are considered standing members of the Network.

Role of the Network

A key role of the Network is to identify, collect, analyse and report data on domestic and family violence related deaths across Australia.

Other elements of the Network's overarching goals include to:

- improve knowledge regarding the frequency, nature and determinants of domestic and family violence deaths;
- identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths;
- analyse and compare themes and issues arising domestic and family violence-related deaths; and
- analyse and compare domestic and family violence death review findings and recommendations.

The Network's unique collection and analysis of data

As a result of identifying the need for national data, the Network has undertaken extensive work to develop and report on a preliminary national dataset of domestic and family violence related deaths ('the National Minimum Dataset').

While death review entities have the capacity to report on domestic and family violence homicide data within their respective jurisdictions, through the Network each entity has sought to collaborate and report national data. Aside from the Network, no other entity has the capacity to provide specialist national data. This has been acknowledged by the Australian Human Rights Commission who, in its 2016 report, stated that:

The only organisations to collect information that is relevant for a national database on domestic and family violence deaths are the members of the Australian Domestic Violence Death Review Network.[2]

Unlike existing homicide census data, such as that produced by the Australian Institute of Criminology's National Homicide Monitoring Program, the information the Network has relied upon in generating the National Minimum Dataset is extensive and specialised to the domestic and family violence death reviews located in individual jurisdictions.

1 National Council of Australian Governments, The National Plan to Reduce Violence Against Women and their Children 2010-2022, (Commonwealth Government, 2009), p. 26.

2 Australian Human Rights Commission, A National System for Domestic and Family Violence Death Review, Sydney, 2017, p. 53.



Network members have specialist expertise in domestic and family violence related issues, access to extensive information by virtue of their specialist review mechanisms and location in Coroners Courts, Ombudsman's offices or government agencies, and many also have the capacity to call for additional information or records as required.

This approach is critical to providing a more informed, holistic understanding of the circumstances and context of a domestic and family violence related death.

The data and information produced by the Network in this report is drawn from the National Minimum Dataset. It provides detailed information regarding histories of domestic and family violence leading up to the homicide, and provides information beyond the fatal episode of violence. As such, this report aims to enhance our understanding of domestic violence homicide in Australia, and to enhance intervention and prevention efforts in this space.

The need for national data

While Network members have been collaborating to develop this data for a number of years, its efforts have sat alongside many other initiatives designed to promote and enhance data collection and reporting of domestic and family violence deaths in Australia.

In October 2016 the Department of Social Services launched the *Third National Action Plan to Reduce Violence against Women and their Children* (2016-2019) ('the National Action Plan').

This plan identified the development of a national database of domestic and family violence deaths as a priority, stating that:

> For the National Action Plan to be successful in achieving its long term target, a solid national evidence base is required.[3]

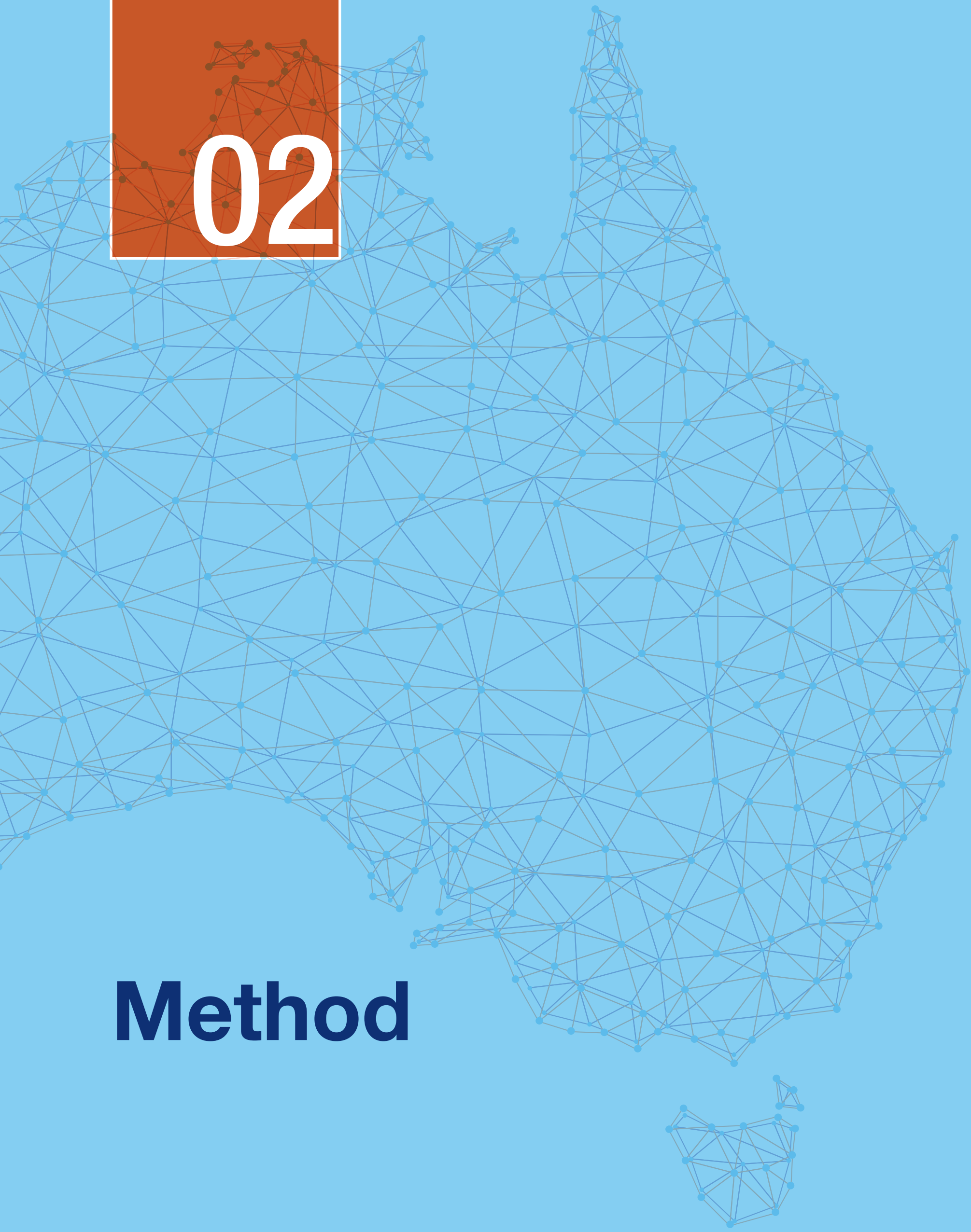
In recognition of this objective, the National Action Plan tasked the Australian Human Rights Commission to progress improvements to systems that support reviews of domestic and family violence related deaths and child deaths. The Australian Human Rights Commission was asked to consult states and territories to scope the development of data collection protocols and a proposed national data collection mechanism.[4]

In taking carriage of this work, the Australian Human Rights Commission announced that it would explore practical options to strengthen Australia's national data collection and reporting mechanisms in relation to domestic and family violence deaths,[5] and would subsequently submit a scoping paper to the Department of Social Services to inform a national model.[6]

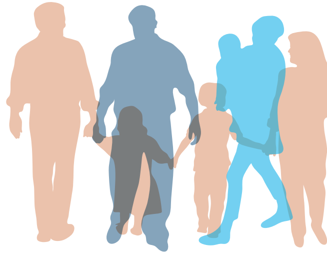
In January 2018 the Network provided the Australian Human Rights Commission with a submission to inform their report to the Department of Social Services. This submission outlined the unique placement of the Network to contribute to and manage the national database on domestic and family violence deaths.

3 Third Action Plan, National Plan to Reduce Violence Against Women and their Children, Department of Social services, Canberra, 2016, p. 26.
4 Third Action Plan, National Plan to Reduce Violence Against Women and their Children, Department of Social services, Canberra, 2016, p. 28.
5 Australian Human Rights Commission, A National System for Domestic and Family Violence Death Review: Consultation Briefing, Sydney, 2017, p. 2.
6 Australian Human Rights Commission, A National System for Domestic and Family Violence Death Review: Consultation Briefing, Sydney, 2017, p. 2.

02



Method



Study Design and Setting

The data outlined in this report was captured through a retrospective population-based case series. This study examined the deaths of people who were killed by their current or former intimate partner following a history of domestic violence in Australia between 1 July 2010 and 30 June 2014.

Data Sources

The presented data was sourced from the Coroners Courts in New South Wales, Victoria, Queensland, South Australia, and the Northern Territory, using information including (but not limited to); the coronial files, briefs of evidence, police reports of death, media reporting, sentencing remarks and agency records. For the Australian Capital Territory, Western Australia and Tasmania, information was sourced from the National Coronial Information System with approvals from those courts.

Case Identification

In order to establish a nationally consistent definition of domestic and family violence homicide the Network's Homicide Consensus Statement ('the Consensus Statement' – see **Appendix B**) was adopted by all members of the Network for implementation within their respective jurisdictional review mechanisms' case identification and inclusion criteria.

The Consensus Statement sets out the processes for identifying and classifying domestic and family violence homicides, taking into consideration the case type, the intent, the relationship between the deceased and the homicide offender, and the domestic and family violence context of the death.

To establish this minimum dataset, each domestic and family violence death review process identified cases from their existing databases that met the following criteria:

- the death was as a result of a homicide that occurred in Australia between 1 July 2010 and 30 June 2014;
- the homicide victim and homicide offender were either in a current or former intimate partner relationship;
- there was an identifiable history of violence between the homicide victim and homicide offender; and
- the coronial or criminal proceedings in that homicide were complete on or before September 2017.

Data Collection

In 2015 Network members commenced testing and development of what would become the first iteration of the National Minimum Dataset. At a Network Summit, Network members sought to generate a list of variables, mapping areas of data collection common to all jurisdictions. The Network subsequently arranged these variables within a database and developed and refined a comprehensive data dictionary. The purpose of this exercise was to identify areas of commonality across each jurisdiction's existing data capabilities, and to identify areas where further data collection would be desirable for future iterations of the dataset.

At this Summit the Network members agreed to collect data variables including:

- details of the homicide event (fatal episode), including the manner, location and date of death;
- socio-demographic characteristics of the homicide victim and homicide offender;
- information regarding the relationship between the homicide victim and homicide offender, including the length of the relationship, details regarding separation, history of violence (reported and unreported), types of violence (physical, psychological, emotional, social and sexual violence), history of stalking, and criminal justice histories (including imprisonment, conviction, other offending);
- criminal justice or coronial outcomes;
- Domestic Violence Order information; and
- prevalence of surviving children (biological or step children).

Throughout 2015 and 2016 Network members conducted preliminary data testing to identify any limitations or challenges with the data collection process, database and data dictionary. Once this testing was refined, the database and data dictionary were disseminated in final form to Network members to enter individual jurisdictional data.

Data Extraction

In September 2017 the Network, and their respective heads of jurisdiction, endorsed the Network's Data Sharing Protocols ('the Protocols' – see **Appendix C**) to facilitate the sharing of domestic and family violence death review data across jurisdictions, in support of the establishment of the National Minimum Dataset. These Protocols recognise each jurisdiction's governance and legislative framework, and establish specifications which all participating jurisdictions agree to, for the purposes of appropriate data collection, storage and dissemination.

Where the homicide case met the criteria for inclusion, data related to the homicide offender and homicide victim was extracted from jurisdictional databases and entered into a central database. Data was extracted by members of the domestic and family violence death review processes in New South Wales, Victoria, Queensland, South Australia, and the Northern Territory. The New South Wales review process additionally extracted data from Coroners Courts in Tasmania, Australian Capital Territory and Western Australia through the National Coronial Information System.

Data Analysis

A series of univariate and bivariate descriptive statistical analyses were performed to describe: details of the homicide episode; socio-demographic characteristics of the homicide victim and homicide offender; relationship characteristics; domestic and family violence behaviours; and Domestic Violence Orders to provide a comprehensive data report on domestic and family violence homicides in Australia.

Limitations

To date reporting of specialist variables including histories of violence (both anecdotal and reported histories) and some contextual data, has been provided by New South Wales, Victoria, South Australia, Queensland and the Northern Territory. Western Australia is currently working to provide data from July 2012, when that jurisdiction commenced its review. At this time, for Western Australia, and jurisdictions where permanent DFV death review processes do not currently exist (Tasmania and Australian Capital Territory) preliminary data was derived from Coroners Courts via the National Coronial Information System.

This means that some data variables reflect data from all states and territories, and other data variables reflect data from only New South Wales, Victoria, South Australia, Queensland and the Northern Territory. This is carefully indicated in the data chapter so as to ensure clarity in reporting.

To date reporting of preliminary data is limited to intimate partner violence homicide cases only. The Network has future plans to enhance this data reporting to include other domestic and family violence related homicides and suicides. It is noted, however, that due to the progress of these datasets being dependent on the resource dedication of individual death review processes, these datasets will be subject to staged development over subsequent reports.



03

Results

The section sets out the Network's quantitative data findings from the National Minimum Dataset including: gender distribution of IPV homicides in Australia, histories of domestic violence in IPV homicides across Australia, relationship characteristics of IPV homicides in Australia (including separation as a characteristic of IPV homicide), current family law proceedings, current Domestic Violence Orders, court outcomes for IPV homicide offenders and demographic information of both IPV homicide victims and homicide offenders.

The data set out in this chapter relates to intimate partner homicides following an identifiable history of domestic and family violence.

As to the terminology adopted in this chapter, it is noted that the term 'family violence' has achieved mainstream usage in many jurisdictions as it expands the definition of domestic violence to encompass abuse within intimate relationships and both immediate and extended families.[7] It is also acknowledged that the term 'family violence' is often preferred by Aboriginal and Torres Strait Islander Australians as it reflects a broader understanding of violence beyond the intimate partner relationship.[8] Due to this data set's focus on intimate partner violence however, the terms 'domestic violence' and 'intimate partner violence' are ordinarily adopted in this chapter to indicate the violence behaviours between the homicide victim and homicide offender prior to the fatal episode of violence.

The final section of data findings present focused data derived from death review processes in New South Wales, Victoria, Queensland, South Australia, and the Northern Territory only (excluding Western Australia, Australian Capital Territory and Tasmania), concerning histories of abusive behaviours used by primary domestic violence abusers against primary victims of violence.

This report contains preliminary descriptive data, and caution must be used in interpreting findings presented in this report.

Intimate partner violence homicides in Australia, 2010-2014

Between 1 July 2010 and 30 June 2014 there were 152 intimate partner homicides across Australia that followed an identifiable history of domestic violence ('IPV homicides'). This figure includes homicides perpetrated by both males and females (*Fig. 1*), and includes homicides of both current and former intimate partners. All homicides were identified as being preceded by either police reported and/or anecdotal histories of domestic violence.

Figure 1: IPV homicides in Australia, 2010-2014 (n=152)

State/Territory	IPV homicides 2010-2014 (n=152)	%
NSW	53	34.9%
QLD	31	20.4%
VIC	26	17.1%
NT	14	9.2%
WA	12	7.9%
SA	10	6.6%
TAS	4	2.6%
ACT	2	1.3%
TOTAL	**152**	**100%**

7 National Council To Reduce Violence Against Women and their Children, Background paper to Time for Action: The National Council's Plan for Australia to reduce violence against women and their children 2009-2021 (Commonwealth Government, 2009).

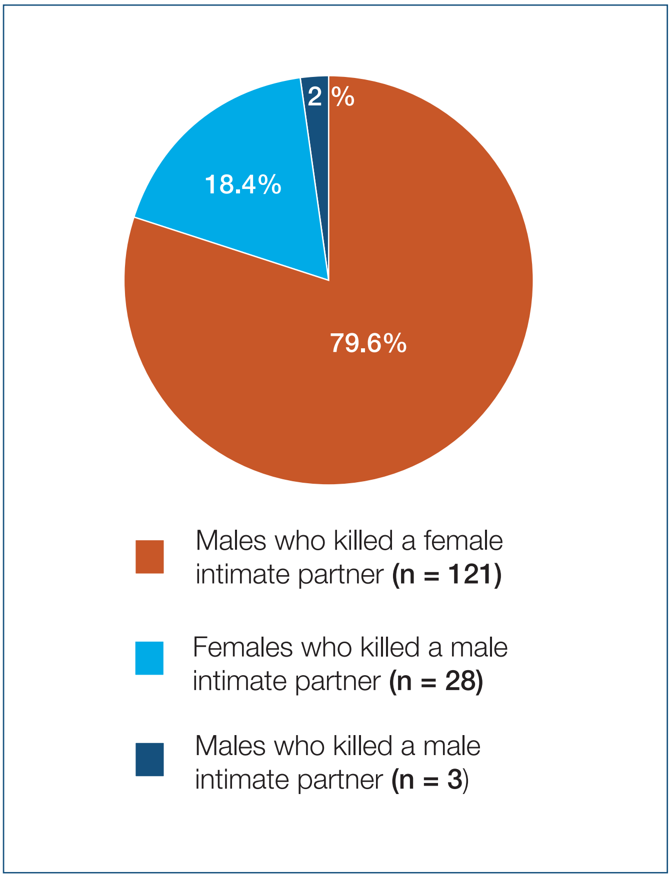
8 A. Olsen and R. Lovett, Existing knowledge, practice and responses to violence against women in Australian Indigenous communities: State of knowledge paper (ANROWS, 2016) available at https://d2c0ikyv46o3b1.cloudfront.net/anrows.org.au/s3fs-public/FINAL%2002.16_3.2%20AIATSIS%20Landscapes%20WEB.pdf (accessed 16 April 2018).



IPV homicides and gender

The majority of IPV homicides across Australia during the data reporting period involved a male killing a female intimate partner (n=121, 79.6%). The remaining IPV homicides involved 28 cases where a female killed a male intimate partner (n=28, 18.4%) and three cases where a male killed a male intimate partner (n=3, 2.0%) (*Fig. 2*).

Figure 2: IPV homicide offenders by gender, 2010-2014 (n=152)



Male IPV homicide offenders, 2010-2014

During the data reporting period, 124 males killed a current or former intimate partner. As indicated above, most (n=121, 97.6%) killed a female intimate partner, and three killed a male intimate partner (2.4%).

This data is presented below distinguishing between males who killed a female partner, and males who killed a male partner.

Histories of domestic violence victimisation/perpetration preceding male perpetrated IPV homicides

Of the 121 males who killed a current or former female intimate partner following a history of domestic violence, 112 of those males were the primary DV abuser against their female partner prior to the homicide (92.6% of all cases involving a male offender killing a female). This means that most male homicide offenders had been the primary user of domestic violence behaviours against the homicide victim prior to her death. Fewer males who killed a female partner had been both a domestic violence victim and domestic violence abuser prior to the homicide (n=3, 2.5% of all cases involving a male offender killing a female). No males killed a female partner who had been a primary DV abuser against them.

In six cases (5.0% of all cases involving a male offender killing a female), there was insufficient information available to determine the male homicide offender's victimisation/perpetration status prior to the homicide (*Fig. 3*).

Figure 3: Male homicide offenders who killed a female IP by domestic violence victimisation/perpetration (n=121)

DV victimisation/ perpetration status	Male homicide offenders (n=121)	%
Primary DV abuser	112	92.6%
Both a DV abuser and a DV victim	3	2.5%
Primary DV victim	0	0%
Unknown	6	5.0%
TOTAL	**121**	**100%**

Of the three males who killed their male intimate partner, two of the male homicide offenders had been the primary DV abuser against the male intimate partner they killed, and one male homicide offender had been a primary victim of violence who killed his male primary DV abuser.

Relationship characteristics in male perpetrated IPV homicides

Relationship types

Of the 121 males who killed a current or former female intimate partner following a history of domestic violence, 37 of those males killed their de facto wife (30.6%), 26 killed their wife (21.5%), 20 killed their former wife (16.5%), 14 killed their girlfriend (11.6%), 13 killed their former de facto wife (10.7%) and 11 killed their former girlfriend (9.1%) (*Fig. 4*).

Of the three males who killed a current or former male intimate partner following a history of domestic violence, two killed their de facto husbands and one killed their boyfriend.

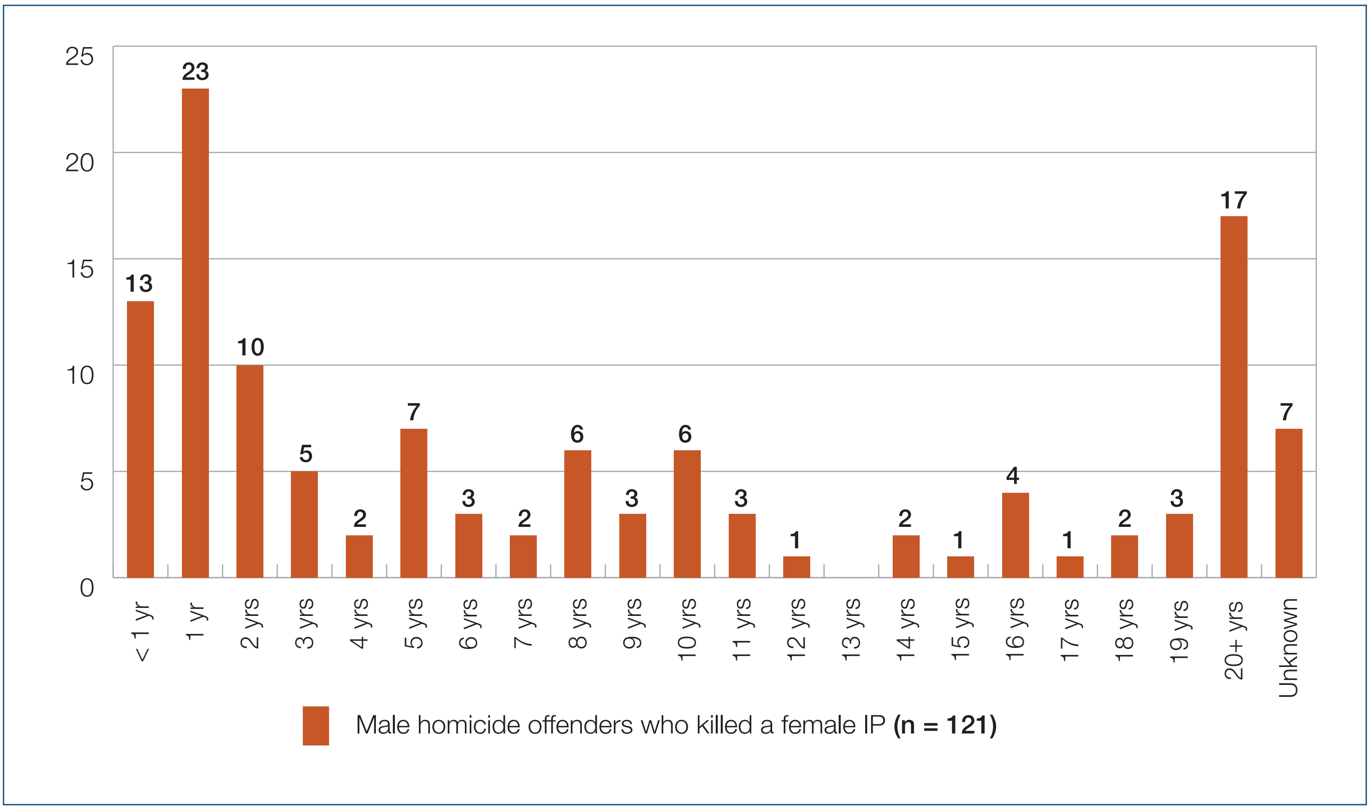
Figure 4: Male homicide offenders who killed a female IP by relationship type (n=121)

Relationship type	Male homicide offenders (n=121)	%
De facto wife	37	30.6%
Wife	26	21.5%
Former wife	20	16.5%
Girlfriend	14	11.6%
Former de facto wife	13	10.7%
Former girlfriend	11	9.1%
TOTAL	**121**	**100%**

Relationship length

Of the 121 male IPV homicide offenders who killed a female partner, 13 killed a partner they had been in a relationship with for less than a year (10.7%). The majority of males killed a partner they had been in a relationship with for between one and ten years (n=67, 55.4%). Around a quarter of males killed a partner they had been in a relationship with for more than ten years (n=34, 28.1%). In seven cases the relationship length was unable to be ascertained (5.8%) (*Fig. 5*).

Figure 5: Length of relationship in male perpetrated IPV homicides against females (n=121)



For the male homicide offenders who killed a current or former male partner, one killed a male partner after being in a relationship for one year, one killed a male partner of seven years and one killed a male partner of 16 years.

Separation as a characteristic of male perpetrated IPV homicides

Separation and intention to separate

Of the 121 male IPV homicide offenders who killed a female partner, 77 (63.6%) killed a current female intimate partner (meaning that the relationship was ongoing at the time of the homicide) and 44 males (36.4%) killed a former female partner.

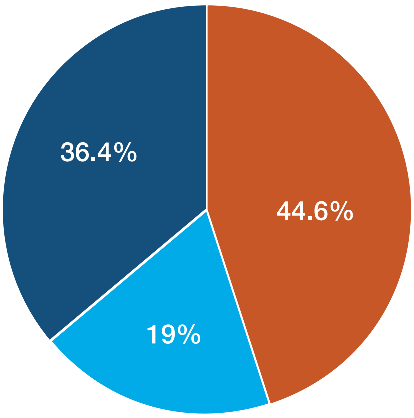
Of the 44 males who killed a former female partner, 21 (47.7%) killed that partner within three months of the separation and 21 (47.7%) killed their former partner in a period greater than three months after separation. In two cases (4.5%) the proximity of the separation to the homicide was unable to be ascertained.

Of the 77 cases in which the relationship was ongoing, in just under a third of these cases, one or both parties had indicated an intention to separate (n=23, 29.9%). In 20 of these 23 cases the female homicide victim had indicated an intention to separate from the male homicide offender, in one case the male homicide offender had indicated an intention to separate from the female homicide victim, and in two cases both the female homicide victim and the male homicide offender had indicated that they were going to end their relationship.[9]

Accordingly, actual or intended separation was a characteristic in 55.4% of cases where males killed a female intimate partner during the data reporting period (n=67) (*Fig. 6*).

9 It is acknowledged that this may be an undercount as in some circumstances the homicide victim or homicide offender may not indicate to any person or service that they are intending to separate from their partner.

Figure 6: Male homicide offenders who killed a female IP by relationship status (n=121)



In all three cases where a male killed a male intimate partner the homicide offender and homicide victim were in a current relationship, but in one case the male homicide victim had indicated an intention to leave the male homicide offender.

Family law proceedings

In five of the 44 cases where a male homicide offender killed a former female intimate partner, family law proceedings had been formally commenced and were on foot at the time of the homicide.

None of the males who killed a male intimate partner were involved in family law proceedings at the time of the homicide.

Domestic Violence Orders in male perpetrated IPV homicides

Each state and territory in Australia has legislation that allows the courts to make Domestic Violence Orders – civil orders designed to protect a victim of domestic violence by prohibiting the abuser (the respondent to the order) from committing further acts of domestic violence against the victim (the person in need of protection).[10]

Of the 121 female homicide victims who were killed by a male homicide offender in an IPV homicide, 29 were protected under a current Domestic Violence Order when they were killed (24.0%). One of these women was named as both a protected person and as a respondent under a cross-Domestic Violence Order. This means that 29 of the males who killed a female intimate partner were named as respondents under current Domestic Violence Orders at the time of the homicide (24.0%), and one of these males was named as both a protected person and a respondent under a cross-Domestic Violence Order.

None of the males who were killed by a male intimate partner were protected or named as a respondent under a Domestic Violence Order when they were killed.

Demographic characteristics of male IPV homicide offenders

Male IPV homicide offender age

The 121 male IPV homicide offenders who killed female homicide victims ranged in age from 19 to 82 years old. The average age of male IPV homicide offenders was 42 years old with a standard deviation of 12.97. The median age of male IPV homicide offenders who killed female homicide victims was 41 years old.

The three males who killed male homicide victims in IPV homicides were aged between 33 and 49 years old.

10 Current legislation: *Domestic Violence and Protection Orders Act 2008* (ACT); *Family Violence Protection Act 2008* (VIC); *Restraining Orders Act 1997* (WA); *Intervention Orders (Prevention of Abuse) Act 2009* (SA); *Domestic and Family Violence Act 2007* (NT); *Domestic and Family Violence Protection Act 2012* (QLD); *Family Violence Act 2004* (TAS); *Crimes (Domestic and Personal Violence) Act 2007* (NSW).



Male IPV homicide offender Aboriginal and Torres Strait Islander status

Of the 121 male IPV homicide offenders who killed females, 24 (19.8%) identified as Aboriginal. Aboriginal and Torres Strait Islander people are overrepresented in this dataset, and this data reflects findings similar to those profiled in National Homicide Monitoring Program.[11] The multi-stratum reasons for this overrepresentation are not examined in this data report and caution must be used in interpreting this data finding.

All Aboriginal males who killed an intimate partner in this dataset killed a female intimate partner.

Male IPV homicide offender employment status

Almost half of the 121 male IPV homicide offenders who killed a female partner were unemployed at the time of the homicide (n=54, 44.6%). Over a third of male IPV homicide offenders were employed (n=42, 34.7%). A small number of male IPV homicide offenders were on a pension (retirement or disability) (n=10, 8.3%) and one was a student. In 14 cases the male IPV homicide offender's employment status was unable to be determined (11.6%) (*Fig. 7*).

Figure 7: Male homicide offenders who killed a female IP by employment status (n=121)

Occupation status	Male homicide offenders (n=121)	%
Unemployed	54	44.6%
Employed	42	34.7%
Retired/pension	5	4.1%
Disability pension	5	4.1%
Student	1	0.8%
Unknown	14	11.6%
TOTAL	**121**	**100%**

Of the males who killed a male intimate partner two were unemployed at the time of the homicide, and one was employed.

Fatal episode characteristics in male perpetrated IPV homicide

Location of homicide

Of the 121 male IPV homicide offenders, the highest number killed the female homicide victim in the residence that they shared (n=53, 43.8%), followed by the homicide victim's residence (n=28, 23.1%) and public/open places (n=16, 13.2%). Nine male homicide offenders killed female victims at 'other residences' (including the houses of friends or relatives), and two male homicide offenders killed their female intimate partners at a workplace (their workplace, a shared workplace, or that of the victim) (*Fig. 8*).

Figure 8: Male homicide offender who killed a female IP by location of homicide (n=121)

Homicide location	Male homicide offenders (n=121)	%
Shared residence	53	43.8%
Homicide victim residence	28	23.1%
Public/open place	16	13.2%
Homicide offender residence	13	10.7%
Other residence	9	7.4%
Workplace	2	1.7%
TOTAL	**121**	**100%**

For the three male homicide offenders who killed male intimate partners, two killed their partner at their shared residence and one killed a male homicide victim at the victim's residence.

11 W. Bryant and S. Bricknell, Homicide in Australia 2012-13 to 2013-14: National Homicide Monitoring Program report (Australian Institute of Criminology, Canberra, 2017).

Mechanism of fatal assault

The highest number of male IPV homicide offenders killed their female intimate partners by assaulting them with a sharp weapon (n=38, 31.4%).[12] Other male IPV homicide offenders killed their female partners by assaulting them without a weapon (n=21, 17.4%), including hitting, beating or kicking the homicide victim.

Other manners of death included suffocating/strangling the homicide victim (n=19, 15.7%), shooting the homicide victim (n=14, 11.6%), multiple assaultive behaviours (n=11, 9.1%), assault with a blunt weapon (n=9, 7.4%) and homicide by arson/fire-related assault (n=3, 2.5%). In six cases the manner by which the male offender killed the female homicide victim was unknown or unable to be ascertained (*Fig. 9*).

Figure 9: Male homicide offenders who killed a female IP by mechanism of fatal assault (n=121)

Mechanism of fatal assault	Male homicide offenders (n=121)	%
Assault – sharp weapon	38	31.4%
Assault – no weapon	21	17.4%
Suffocation/ strangulation	19	15.7%
Firearms	14	11.6%
Multiple assaultive behaviours	11	9.1%
Assault – blunt weapon	9	7.4%
Arson/fire related	3	2.5%
Unknown	6	5.0%
TOTAL	**121**	**100%**

Of the three male IPV homicide offenders who killed male homicide victims, one male homicide offender suffocated/strangled the male victim, one assaulted the male victim with a blunt weapon and one assaulted the male victim with a sharp weapon.

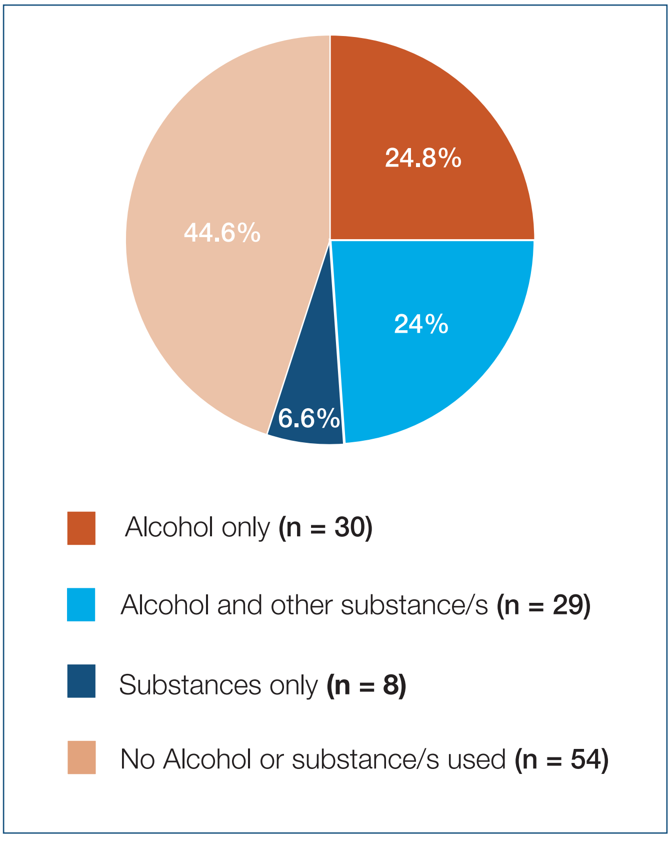
Male IPV homicide offender alcohol and/or other drug use at time of fatal episode

The information contained in this section is based on toxicology testing, witness statements, and on self-reports concerning the homicide offender's alcohol and other drug use at the time of the homicide. Of the 121 male IPV homicide offenders who killed a female homicide victim, almost half were using alcohol at the time of the fatal episode (n=59, 48.8%), and 30.6% were using other substances (including pharmaceutical or other non-therapeutic drugs) at the time of the fatal episode (n=37).

Of the 59 male IPV homicide offenders that were using alcohol, just over half (n=30, 50.8%) were using alcohol only and half (n=29, 49.2%) were using alcohol together with other substances.

Accordingly, eight male IPV homicide offenders were using substances only at the time of the fatal assault (*Fig. 10*).

Figure 10: Male homicide offenders who killed a female IP by alcohol and/or other substance use at fatal episode (n=121)



12 Primarily assaults with knives.



This data does not purport to assess the impact the alcohol and/or substance use had on the male IPV homicide offender at the time of the homicide.

Of the three male IPV homicide offenders who killed male homicide victims, one was using both alcohol and other substances at the time of the homicide, one was using substances only, and one was not using alcohol or other substances at the time of the homicide.

Male IPV homicide offender suicide after homicide

Of the 121 male IPV homicide offenders who killed a female homicide victim, over 20% died by suicide after killing the homicide victim (n=26, 21.5%).

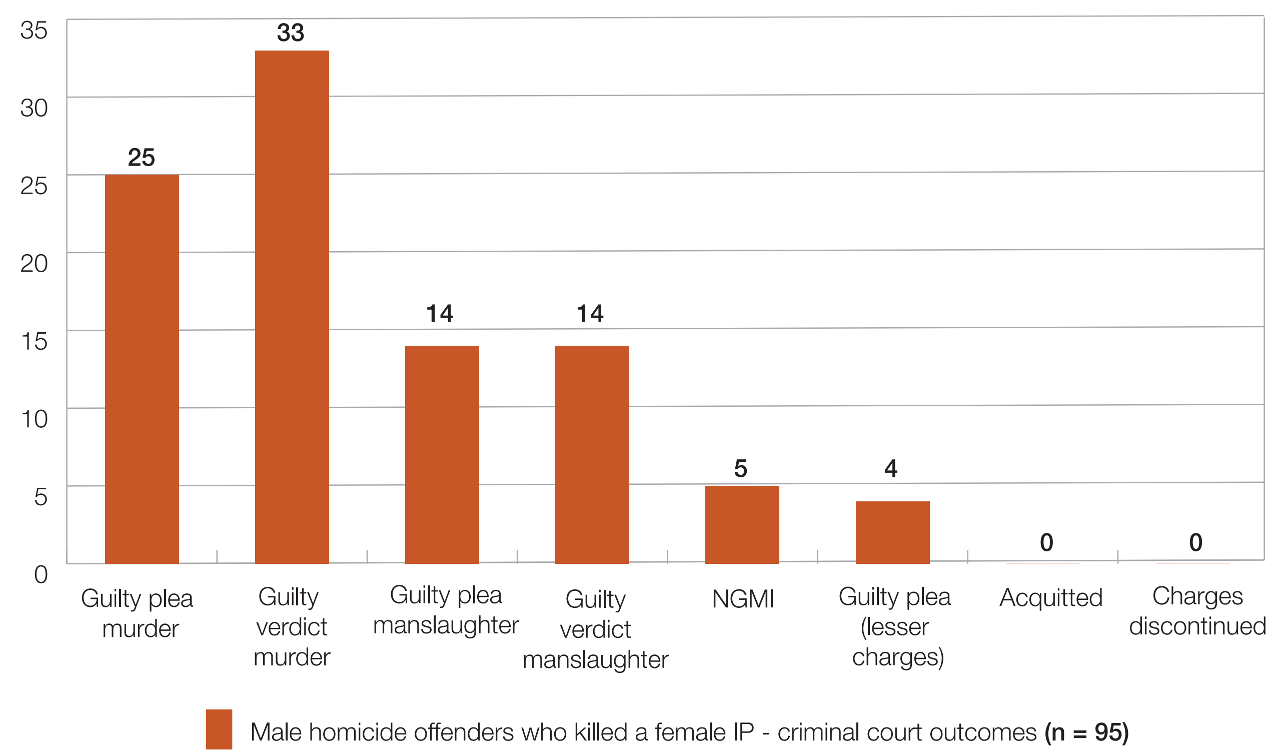
None of the male IPV homicide offenders who killed a male homicide victim died by suicide after the homicide.

Criminal court outcomes in male perpetrated IPV homicides

For the 95 males who killed a female intimate partner where a criminal investigation was completed (i.e. those where the male homicide offender did not suicide), the most common outcome was a murder conviction (n=58, 61.1%). Over one-quarter were convicted of manslaughter (n=28, 29.5%). Just over 5% of male IPV homicide offenders who killed a female were found not guilty by reason of mental illness (n=5, 5.3%). Four male offenders pleaded guilty to lesser charges (4.2%) (*Fig. 11*).

Of the three male IPV homicide offenders who killed a male intimate partner, two were acquitted of all charges and one pleaded guilty to murder.

Figure 11: Criminal court outcomes in male perpetrated IPV homicides (n=95)



Female victims of IPV homicide, 2010-2014

As noted above, in the data reporting period 1 July 2010 to 30 June 2014, 121 females were killed by a male intimate partner following an identifiable history of domestic violence. This section presents demographic data in relation to the homicide victims considered in this dataset.

Female IPV homicide victim demographics

Female IPV homicide victim age

Females who were killed by male IPV homicide offenders ranged in age from 16 to 78 years old, with an average age of 37.6 years, with a standard deviation of 12.43. The median age of females killed by male IPV homicide offenders was 35 years old.

Female IPV homicide victim country of birth

Almost three-quarters of the 121 female IPV homicide victims were born in Australia (n=90, 74.4%). The remaining 31 female IPV homicide victims were born outside of Australia (*Fig. 12*).

Female IPV homicide victim Aboriginal and Torres Strait Islander status

Of the 121 female IPV homicide victims, 27 (22.3%) identified as Aboriginal. This is an overrepresentation based on current Aboriginal and Torres Strait Islander population estimates and reflects the findings of other data sources such as National Homicide Monitoring Program.[13] This data report does not purport to examine the multi-stratum challenges facing Aboriginal women who experience violence, and this data should be read in conjunction with other literature examining Aboriginal and Torres Strait Islander family violence in Australia.

Figure 12: Female IPV homicide victim country of birth (n=121)

Country of Birth	Female homicide victims (n=121)	%
Australia	90	74.4%
Bosnia	1	0.8%
Canada	2	1.7%
China	3	2.5%
Ethiopia	1	0.8%
Fiji	5	4.1%
Greece	1	0.8%
India	3	2.5%
Iran	1	0.8%
Italy	2	1.7%
Japan	1	0.8%
Kazakhstan	1	0.8%
Lebanon	1	0.8%
Macedonia	1	0.8%
New Zealand	1	0.8%
Poland	1	0.8%
Sudan	3	2.5%
United Kingdom	2	1.7%
Vietnam	1	0.8%
TOTAL	**121**	**100%**

13 W. Bryant and S. Bricknell, Homicide in Australia 2012-13 to 2013-14: National Homicide Monitoring Program report (Australian Institute of Criminology, Canberra, 2017).



Female IPV homicide victim employment status

About a third of the 121 female IPV homicide victims were engaged in paid employment at the time of the homicide (n=44, 36.4%). Almost half of the female IPV homicide victims were unemployed at the time of the homicide (n=54, 44.6%). In seven cases the female IPV homicide victim was retired at the time of the homicide (5.8%). In six cases the female IPV homicide victim was on a disability pension (5.0%) and in six cases the female IPV homicide victim was a student at the time of the homicide (5.0%). In four cases the employment status of the female IPV homicide victim was not able to be ascertained (*Fig. 13*).

Figure 13: Female IPV homicide victim employment status (n=121)

Occupation status	Female homicide victims (n=121)	%
Unemployed	54	44.6%
Employed	44	36.4%
Retired/pension	7	5.8%
Disability pension	6	5.0%
Student	6	5.0%
Unknown	4	3.3%
TOTAL	**121**	**100%**

Female IPV homicide victim pregnancy

Two of the 121 female IPV homicide victims were pregnant when they were killed by a male intimate partner in an IPV homicide.

Female IPV homicide offenders, 2010-2014

During the reporting period, there were 28 female IPV homicide offenders. In all cases the female homicide offender killed a male homicide victim.

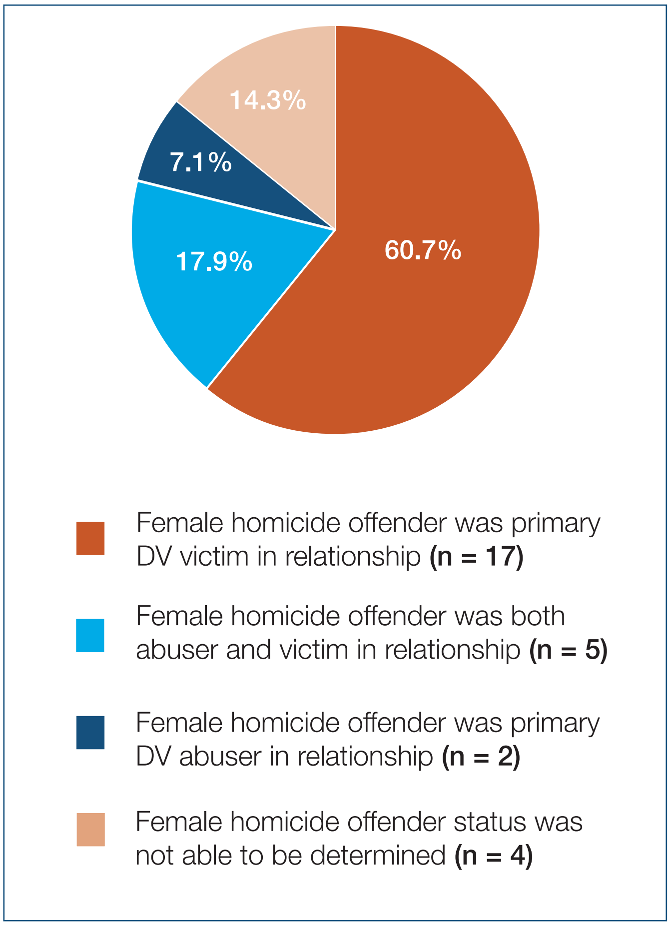
Histories of domestic violence victimisation/perpetration preceding female perpetrated IPV homicides

Of the 28 female perpetrated IPV homicides, in the majority of cases the female IPV homicide offender was the primary domestic violence victim in the relationship and the male homicide victim was the primary domestic violence abuser before the death (n=17, 60.7%). This means that in most cases of female perpetrated IPV homicide, a female killed her abusive current or former male partner.

In five cases (17.9% of all female perpetrated IPV homicides) the female IPV homicide offender was both a domestic violence victim and abuser in the relationship (no primary abuser was identifiable), and in two cases the female IPV homicide offender was a primary domestic violence abuser who killed a male victim of domestic violence.

In four cases the female IPV homicide offender's victimisation/perpetration status was unable to be ascertained (*Fig.14*).

Figure 14: Female homicide offenders by domestic violence victimisation/perpetration (n=28)



Relationship characteristics in female perpetrated IPV homicides

Relationship types

Of the 28 female IPV homicide offenders, the highest number killed their de facto husband (n=18, 64.3%), followed by their former de facto husband (n=4, 14.3%), their husband (n=3, 10.7%), boyfriend (n=2, 7.1%), and former boyfriend (n=1, 3.6%) (*Fig. 15*).



Figure 15: Female homicide offender by relationship type (n=28)

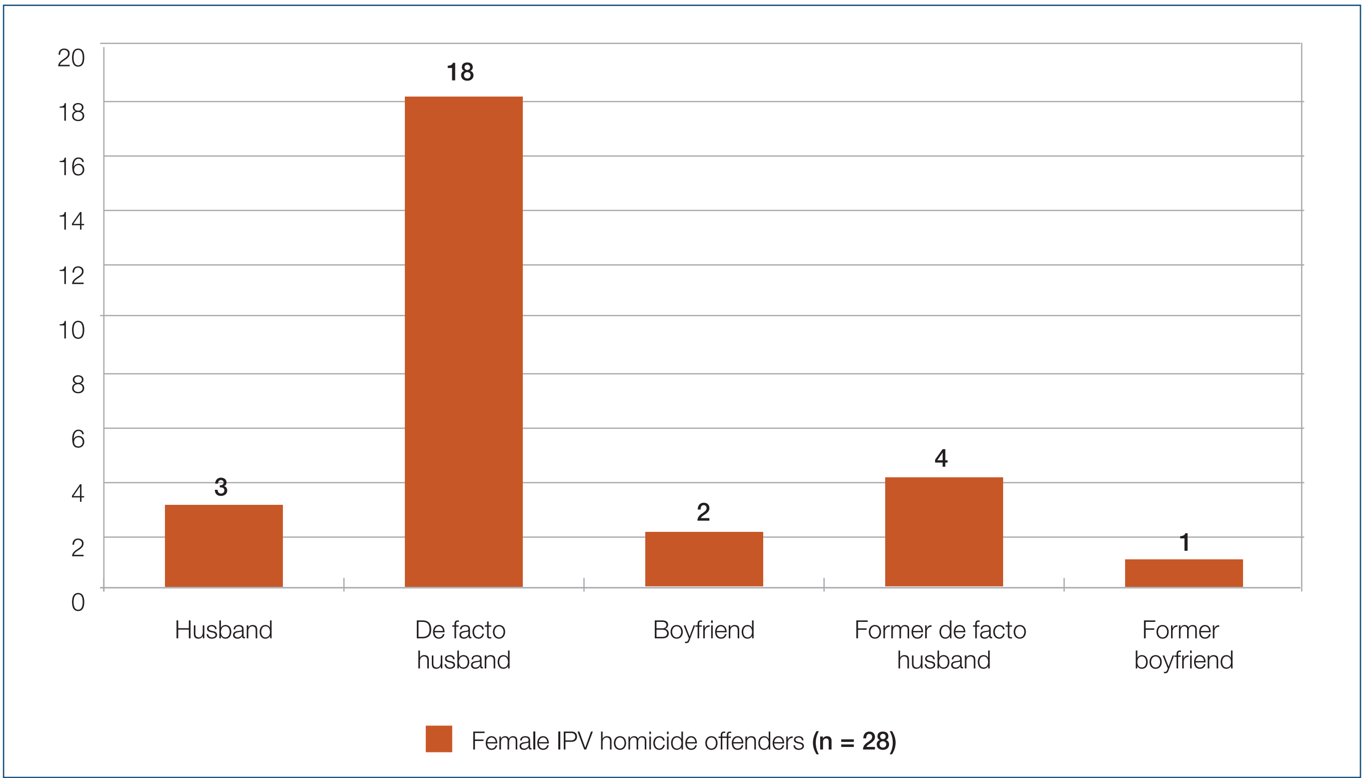
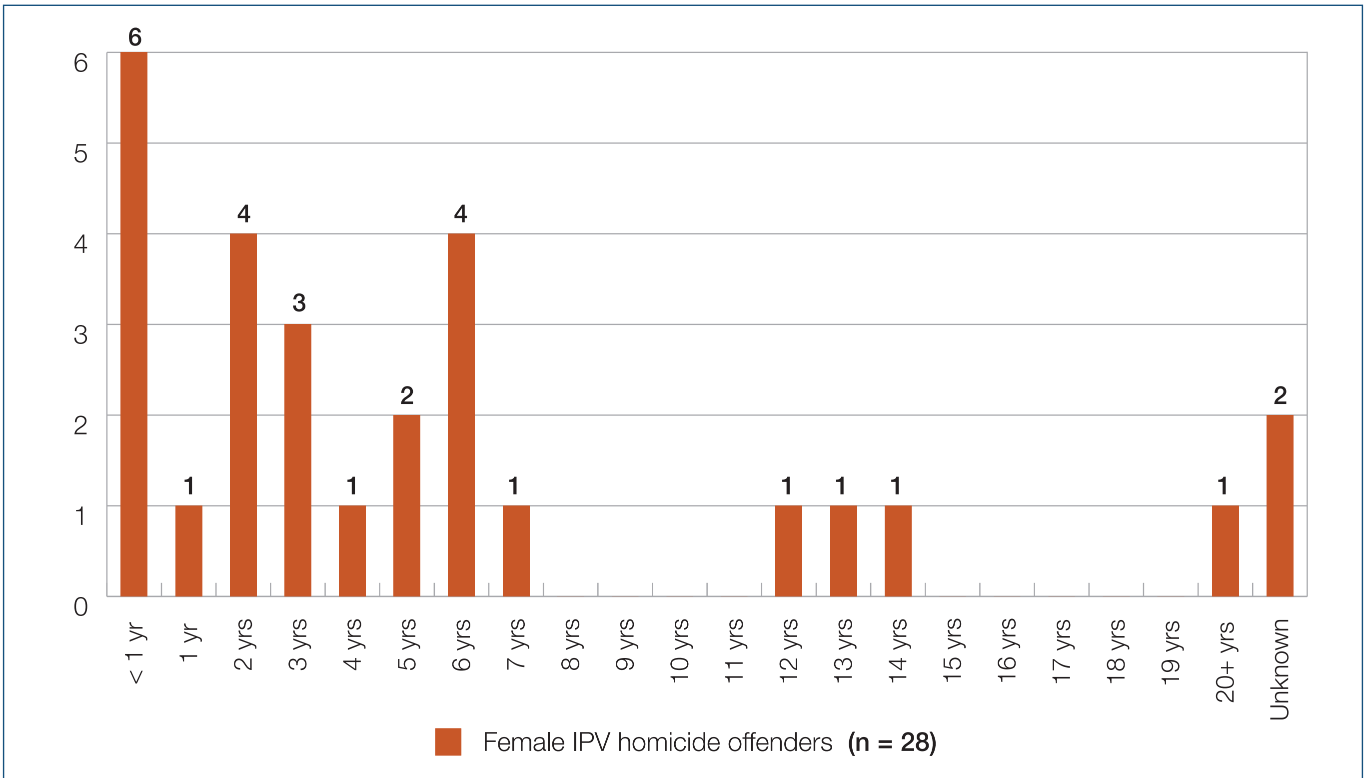


Figure 16: Length of relationship in female perpetrated IPV homicides (n=28)



Relationship length

Of the 28 female IPV homicide offenders, 21.4% killed a male intimate partner they had been with for less than a year (n=6). Most female IPV homicide offenders killed a male intimate partner with whom they had been in a relationship with for between one and seven years (n=16, 57.1%) (*Fig. 16*).

Separation as a characteristic of female perpetrated IPV homicides

Separation and intention to separate

Of the 28 female IPV homicide offenders, the majority killed a male intimate partner they were currently in a relationship with (n=23, 82.1%), meaning that the relationship was ongoing at the time of the homicide. Just under a fifth of female IPV homicide offenders (n=5, 17.9%) killed a former male intimate partner.

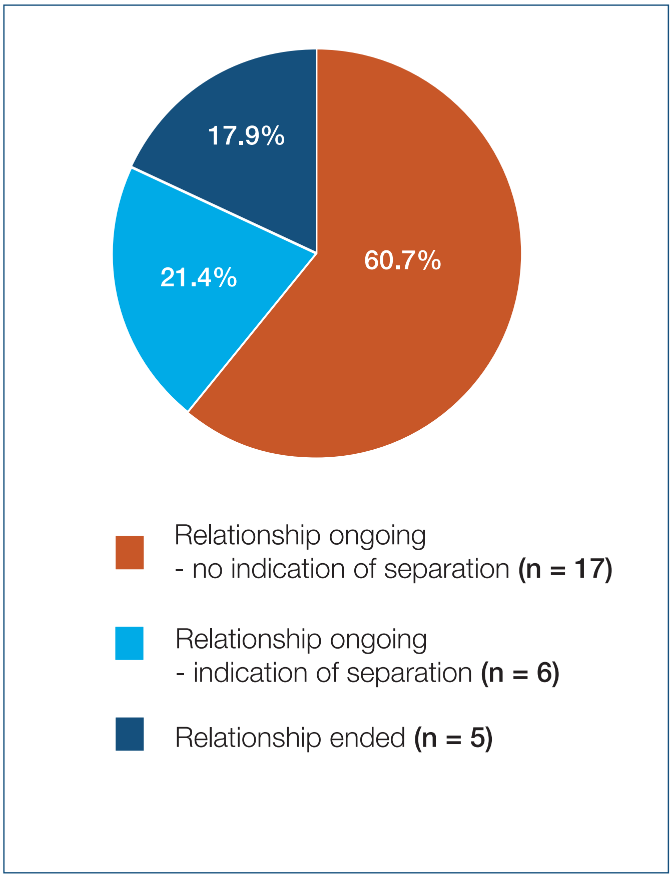
Of the five females who killed a former male intimate partner, three killed that partner more than three months after the separation, and two killed their intimate partners within three months of the separation.

Of the 23 cases in which the relationship was ongoing, in 26.1% of these cases, one or both parties had indicated an intention to separate (n=6).

In three of these cases the male homicide victim had indicated an intention to separate from the female IPV homicide offender, in two cases both the male homicide victim and female IPV homicide offender had indicated that they were going to end their relationship, and in one case the female IPV homicide offender had indicated an intention to separate from the male homicide victim.[14]

Accordingly, actual or intended separation (proximal or distal) was a characteristic in 39.3% of the female perpetrated IPV homicides during the data reporting period (n=11) (*Fig. 17*).

Figure 17: Female homicide offenders by relationship status (n=28)



Family law proceedings

In two of the five cases where females killed a former male partner, family law proceedings between the female IPV homicide offender and the homicide victim had been formally commenced and were in progress at the time of the homicide.

14 It is acknowledged that this may be an undercount as in some circumstances the homicide victim or homicide offender may not indicate to any person or service that they are intending to separate from their partner.



Domestic Violence Orders in female perpetrated IPV homicides

As noted previously, each state and territory in Australia has legislation that allows the courts to make Domestic Violence Orders – civil orders designed to protect a victim of domestic violence by prohibiting the abuser (the respondent to the order) from committing further acts of domestic violence against the victim (the person in need of protection).[15]

Of the 28 males who were killed by a female intimate partner, seven were named as a respondent under a Domestic Violence Order protecting the female domestic violence victim who killed them (25.0%). This means that seven females who killed male intimate partners were protected under Domestic Violence Orders at the time of the homicide. Four males who were killed by an intimate partner were protected under a current Domestic Violence Order naming the female homicide offender as the respondent (14.3%). In addition to the above figures, there was one case of a male homicide victim who was killed by a female homicide offender, where that male was both protected and named as a respondent under a cross-Domestic Violence Order.

Demographic characteristics of female IPV homicide offenders

Female IPV homicide offender age

The 28 female IPV homicide offenders ranged in age from 19 to 68 years old. Homicide offenders were an average of 34.8 years old, with a standard deviation of 12.49. Female homicide offender's median age was 32 years old.

Female IPV homicide offender Aboriginal and Torres Strait Islander status

Almost half of the 28 female IPV homicide offenders identified as Aboriginal (n=13, 46.4%). In these 13 cases, a history of the female IPV homicide offender being the primary victim of domestic violence in the relationship was identifiable in six cases (46.2%). In four cases the female IPV homicide offender was identified as both a domestic violence victim and abuser (30.8%). In one case the female IPV homicide offender was identified as the primary domestic violence abuser in the relationship, and in two cases information about domestic violence victimisation/perpetration status was unable to be determined.

The complex factors shaping Aboriginal and Torres Strait Islander women's experiences of domestic violence and uses of violence are not considered in this report, and caution should be adopted in interpreting this data. Again, this data should be read in conjunction with other literature examining Aboriginal and Torres Strait Islander family violence in Australia.

Female IPV homicide offender employment status

Almost half of all female IPV homicide offenders were unemployed at the time of the homicide (n=13, 46.4%). About one-fifth of the female IPV homicide offenders were employed (n=6, 21.4%) and one was on a pension. In eight cases the female IPV homicide offender's employment status was unable to be determined (28.6%) (*Fig. 18*).

Figure 18: Female homicide offenders by employment status (n=28)

Occupation status	Female homicide offenders (n=28)	%
Unemployed	13	46.4%
Employed	6	21.4%
Retired/pension	1	3.6%
Unknown	8	28.6%
TOTAL	**28**	**100%**

Female IPV homicide offender pregnancy

One of the 28 female IPV homicide offenders was pregnant at the time of the homicide. This female offender killed her abusive male partner.

15 Current legislation: *Domestic Violence and Protection Orders Act 2008* (ACT); *Family Violence Protection Act 2008* (VIC); *Restraining Orders Act 1997* (WA); *Intervention Orders (Prevention of Abuse) Act 2009* (SA); *Domestic and Family Violence Act 2007* (NT); *Domestic and Family Violence Protection Act 2012* (QLD); *Family Violence Act 2004* (TAS); *Crimes (Domestic and Personal Violence) Act 2007* (NSW).

Fatal episode characteristics in female perpetrated IPV homicides

Location of homicide

Of the 28 female IPV homicide offenders, the majority of females killed the male homicide victim in the residence that they shared (n=12, 42.9%), followed by public/open place (n=5, 17.9%). In four cases the fatal episode occurred in the homicide victim's residence (14.3%). In four cases the fatal episode occurred in the homicide offender's residence (14.3%). In three cases the fatal episode occurred in another residence (10.7%) (*Fig. 19*).

Figure 19: Female homicide offenders by location of homicide (n=28)

Homicide location	Female homicide offenders (n=28)	%
Shared residence	12	42.9%
Public/open place	5	17.9%
Homicide victim residence	4	14.3%
Homicide offender residence	4	14.3%
Other residence	3	10.7%
Workplace	0	0%
TOTAL	**28**	**100%**

Mechanism of fatal assault

The majority of female IPV homicide offenders killed the homicide victim by assaulting them with a sharp weapon (n=23, 82.1%).[16] The second highest number of female IPV homicide offenders killed the homicide victim by assault with a blunt weapon (n=3, 10.7%). One female IPV homicide offender killed her homicide victim by shooting (n=1, 3.6%) and in one case a female IPV homicide offender ran over the homicide victim with her car (n=1, 4.0%) (*Fig. 20*).

Figure 20: Female homicide offenders by mechanism of fatal assault (n=28)

Mechanism of fatal assault	Female homicide offender (n=28)	%
Assault – sharp weapon	23	82.1%
Assault – blunt weapon	3	10.7%
Firearms	1	3.6%
Other	1	3.6%
TOTAL	**28**	**100%**

Female IPV homicide offender alcohol and/or other drug use at time of fatal episode

The information contained in this section is based on toxicology testing, witness statements, and on self-reports concerning the homicide offenders alcohol and other drug use at the time of the homicide.

Half of the 28 female IPV homicide offenders were known to be using alcohol at the time of the fatal episode (n=14, 50.0%), and a quarter were using other substances at the time of the fatal episode (n=7, 25.0%).

Of the 14 female IPV homicide offenders that were using alcohol, eight were using alcohol only and six were using alcohol together with other substances. Accordingly, one female IPV homicide offender was using a substance/s only at the time of the fatal assault (*Fig. 21*).

This data does not purport to assess the impact the alcohol and/or substance use had on the female IPV homicide offender at the time of the homicide.

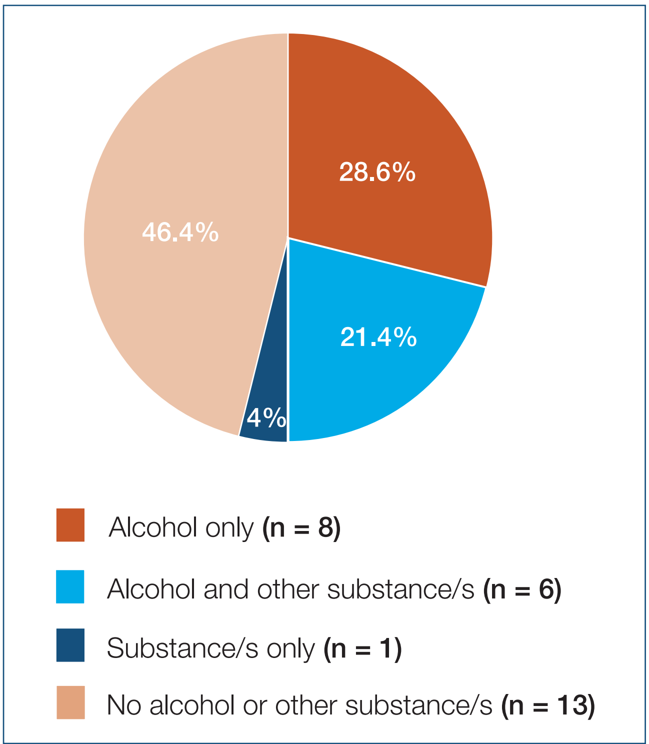
Female IPV homicide offender suicide after homicide

Of the 28 female IPV homicide offenders, one died by suicide immediately following the homicide.

16 Primarily assaults with knives.



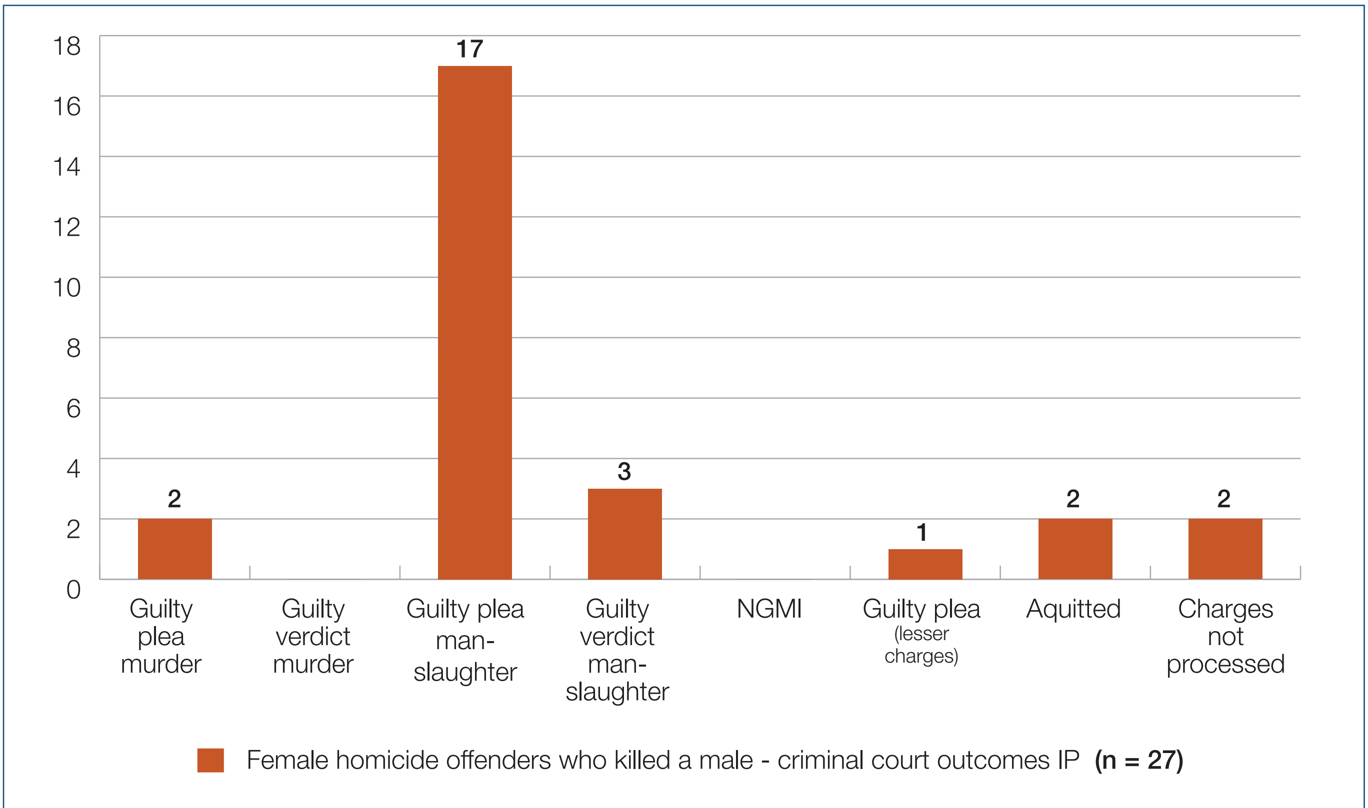
Figure 21: Female homicide offenders by alcohol and/or other substance use at fatal episode (n=28)



Criminal court outcomes in female perpetrated IPV homicide

Of the 27 female homicide offenders whose cases proceeded to criminal investigation, most were convicted of manslaughter (n=20, 74.1%). Two female IPV homicide offenders were convicted of murder (7.4%, both women having submitted a plea of guilty to murder). Two female IPV homicide offenders were acquitted (7.4%), two female IPV homicide offenders had their charges dropped (7.4%) and one female IPV homicide offender was convicted of a lesser charge (3.7%) (*Fig. 22*).

Figure 22: Criminal court outcomes in female perpetrated IPV homicides (n=27)



Male victims of IPV homicide, 2010-2014

As noted above, in the data reporting period 1 July 2010 to 30 June 2014, 31 males were killed by an intimate partner following an identifiable history of domestic violence. Of these 31 males, 28 were killed by a female intimate partner and three were killed by a male intimate partner.

Male IPV homicide victim demographics

Male IPV homicide victim age

Males who were killed in IPV homicides ranged in age from 21 to 58 years old, with an average age of 39 years, and a standard deviation of 11.39. The median age of male IPV homicide victims was 37 years old.

Male IPV homicide victim country of birth

Almost all of the 31 male IPV homicide victims were born in Australia (n=25, 80.6%). The remaining six male IPV homicide victims were born outside of Australia (*Fig.23*).

Figure 23: Male IPV homicide victim country of birth (n=31)

Country of Birth	Male homicide victims (n=31)	%
Australia	25	80.6%
China	1	3.2%
India	2	6.5%
Lebanon	1	3.2%
New Zealand	1	3.2%
United States	1	3.2%
TOTAL	**31**	**100%**

Male IPV homicide victim Aboriginal and Torres Strait Islander status

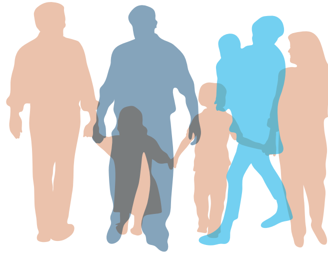
Of the 31 male IPV homicide victims, 11 (35.5%) identified as Aboriginal. In five of these cases, the male IPV homicide victim was identified as primary domestic violence abuser in the relationship prior to the homicide. In three cases the male was both a domestic violence victim and an abuser in the relationship prior to the homicide. In one case the male IPV homicide victim was identified as the primary domestic violence victim in the relationship. In two cases this information was unable to be determined. Again it is noted that the multi-stratum reasons for this overrepresentation are not considered in this report. Accordingly caution must be used in interpreting these findings and this data should be read in conjunction with other literature examining Aboriginal and Torres Strait Islander family violence

Male IPV homicide victim employment status

Over half of the 31 male IPV homicide victims were engaged in paid employment at the time they were killed (n=16, 51.6%). Almost 40% of the male IPV homicide victims were unemployed (n=12, 38.7%), one was on a disability pension and in two cases the employment status of the male IPV homicide victim was not able to be ascertained (*Fig. 24*).

Figure 24: Male IPV homicide victim employment status (n=31)

Occupation status	Male homicide victims (n=31)	%
Employed	16	51.6%
Unemployed	12	38.7%
Disability pension	1	3.2%
Retired/pension	0	0%
Student	0	0%
Unknown	2	6.5%
TOTAL	**31**	**100%**



IPV homicide and children

In this dataset, two children were killed in addition to their female parent in one of the cases of intimate partner violence homicide perpetrated by a male.

However, this dataset also captures information in relation to surviving children who have a parent kill, or be killed, in an intimate partner homicide. The IPV homicide offenders and homicide victims in this dataset were parents (either together or separately) to at least 107 children (including biological children and step-children) who were less than 18 years old at the time of the homicide. Accordingly, for the 152 IPV homicides described in this chapter, the Network has identified that there were at least 107 child survivors of homicide who had a parent kill, and/or be killed.

Histories of domestic violence behaviours preceding homicides

As indicated in the preceding chapters, DFV death review mechanisms are uniquely placed to conduct in-depth and specialised research concerning histories of domestic violence preceding fatal cases. This section accordingly draws on the expertise of those bodies, comprising data from death review processes in New South Wales, Victoria, Queensland, South Australia and the Northern Territory, as these are the jurisdictions where DFV death review mechanisms have been empowered to contribute this specific information to the National Minimum Dataset. This section presents specialised information concerning the histories of violence that preceded homicides, focusing on the behaviours used by primary domestic violence abusers before they killed primary victims of violence.

As noted above in the methodology chapter, each DFV death review mechanism has the ability to call for additional information or records, and accordingly review bodies have extensive access to information around reported and anecdotal histories of violence in deriving this data.

Of the 137 cases that occurred within New South Wales, Victoria, Queensland, South Australia and the Northern Territory, 109 cases involved a primary abuser of domestic violence killing the person they had historically used violence against. This section examines these 109 cases. This number includes 105 cases in which a male domestic violence abuser killed a female domestic violence victim, two cases in which a male abuser killed a male domestic violence victim, and two cases in which a female domestic violence abuser killed a male domestic violence victim.

This section does not include cases where the homicide offender was both a domestic violence abuser and domestic violence victim, or where the domestic violence status could not be established, and this section excludes cases where primary DV victims killed an abuser.

Physical violence

The definition of physical violence adopted by the Network includes any assault on the body without a weapon such as shaking, slapping, pushing, spitting, punching, non-lethal strangulation, kicking or pulling hair. Physical violence also includes any assault on the body using a weapon.

Of the 105 male primary domestic violence abusers who killed female domestic violence victims, 80 of those males had previously used physical violence against the female they killed (76.2%). In 23.8% of cases there was no anecdotal or reported history of physical violence by the male homicide offender against the female homicide victim before he killed her (n=25).

The two male primary domestic violence abusers who killed male partners had both used physical violence against the male homicide victim prior to the episode of violence in which they killed them.

The two female primary domestic violence abusers who killed male partners had both used physical violence against the male homicide victims they killed prior to the homicide.

Emotional psychological abuse

The definition of emotional/psychological abuse adopted by the Network encompasses a broad spectrum of behaviours employed by abusers in order to frighten, belittle, humiliate, unsettle and undermine a victim's sense of self-worth. This can include verbally denigrating the victim; making threats regarding custody of children as a means to control the victim; blaming the victim for all adverse events; fabricating or exploiting a victim's mental illness; and deliberately creating dependence.

Of the 105 male primary domestic violence abusers who killed female domestic violence victims, 84 of those males had previously used emotional and/or psychological violence against the female partners they killed (80.0%).

The two male primary domestic violence abusers who killed male partners had both used emotional/psychological violence against the male homicide victim prior to the episode of violence in which they killed them.

Of the two cases in which a female primary domestic violence abuser had killed a male homicide victim, one female had previously used emotional/psychological violence against the male she killed and in the other case there was no evidence that the female homicide offender had been emotionally abusive prior to the homicide.

Social abuse

The definition of social abuse adopted by the Network includes behaviours employed by abusers to systematically isolate and/or alienate victims from friends, family and colleagues. This can include forbidding or physically preventing the victim from going out and interacting with or meeting people; ongoing antagonistic behaviour towards a victim's support/social network; or any other behaviours that deliberately isolate the victim from established social circles or employment opportunities (including geographical relocation).

Of the 105 male primary domestic violence abusers who killed female domestic violence victims, 64 of those males had previously socially abused the female they killed (61.0%).

One of the two male primary domestic violence abusers who killed male partners had socially abused the male homicide victim prior to the episode of violence in which they killed them.

Neither of the two female primary domestic violence abusers who killed male partners had socially abused the male homicide victims they killed prior to the homicide.

Sexual violence

The definition of sexual violence adopted by the Network includes any form of sexual assault or sexual activity without consent; causing pain during sex; coercive unsafe sex; and forcing the victim to pose for or watch pornography.

Of the 105 male primary domestic violence abusers who killed female domestic violence victims, 13 of those males had previously used sexual violence against the female victim they killed (12.4%).

Neither of the male primary domestic violence abusers who killed male partners had sexually abused the male homicide victim prior to the episode of violence in which they killed them.

Neither of the two female primary domestic violence abusers who killed male partners had sexually abused the male homicide victims they killed prior to the homicide.

Stalking

The definition of stalking adopted by the Network involves a range of tactics whereby a domestic violence abuser intentionally and persistently pursues a victim in order to control or intimidate that victim or seek to make the victim fearful. Stalking behaviours can include the abuser following the victim, loitering near the victim's home or work, and breaking into the victim's house. Stalking also includes acts of technology facilitated abuse such as persistent text messaging; maintaining surveillance over the victim's phone or email; covertly recording the victim's activities; and engaging with the victim on social media/dating sites under a false identity.

Stalking can occur both during an intimate relationship or after a relationship has ended.

Of the 105 male primary domestic violence abusers who killed female domestic violence victims, in 67 cases the relationship was ongoing at the time of the homicide (63.8%) and in 38 cases the relationship had ended at the time of the homicide (36.2%). Of the 67 cases where the relationship was ongoing, in 19 cases the male primary domestic violence abuser had stalked female homicide victim prior to the homicide (28.4%). Of the 38 cases where the relationship had ended at the time of the homicide, in 12 cases the male primary domestic violence abuser had stalked the female both during the relationship and after the relationship had ended (31.6%); in six cases the male had stalked the female only after the relationship had ended (15.8%); and in one case the male had stalked the female during the relationship only (2.6%).

Accordingly, of the 105 male primary domestic violence abusers who killed female domestic violence victims, stalking by that abuser (either during the relationship,



after the relationship had ended, or both) was a feature in 38 cases (36.2%).

Neither of the male primary domestic violence abusers who killed male partners had stalked the male homicide victim prior to the homicide.

One of the two female primary domestic violence abusers who killed male partners had stalked the male homicide victim prior to the homicide. This female stalked the male only after the relationship had ended.

Summary of key findings

Overview

Between 1 July 2010 and 30 June 2014 there were 152 intimate partner homicides in Australia which followed an identifiable history of domestic violence (including a reported and/or anecdotal history of violence) ('IPV homicides').

The majority of these IPV homicides involved a male killing their female (current or former) intimate partner (n=121, 79.6%), and the majority of those males who killed a female had been the primary DV abuser against that female prior to her death (n=112, 92.6%).

Fewer IPV homicides involved a female killing her male (current or former) intimate partner (n=28, 18.4% of all homicides), but of these cases, most of the female homicide offenders were primary victims of violence who killed a male abuser (n=17, 60.7% of female perpetrated IPV homicides).

In some cases where a female homicide offender killed a male partner there was evidence that domestic violence went both ways prior to the fatal episode, meaning that the female offender had both abused and been victimised by the male she killed (n=5, 17.9%). In fewer cases, the male homicide offender killed a female partner in circumstances where he had been both victimised and abused by that female partner (n=3, 2.5% of male perpetrated IPV homicides).

Two of the female homicide offenders who killed a male partner had been primary abusers against the male victim prior to the homicide, but none of the male homicide offenders killed a female who was a primary abuser against them.

There were three males who killed a male intimate partner in this dataset – two of those males were primary DV abusers who killed a male domestic violence victim, and one of those males was a primary DV victim who killed their abusive male partner.

No females in this dataset killed a current or former female partner.

Males who killed females

As noted above, the majority of males who killed a female current or former partner had been the primary DV abuser against that partner prior to the homicide (92.6%).

Most males killed female partners they had been in a relationship with for between one and ten years (n=67, 55.4%). Only around 10% of males killed a female partner they had been with for less than a year (n=13, 10.7%).

Most males killed their current female partners (n=77, 63.6%), and fewer killed former female partners (n=44, 36.4%). Almost half of the males who killed a former female partner killed that partner within three months of the relationship ending (n=21, 47.7%).

Of the cases in which the relationship between the female homicide victim and male offender was ongoing at the time of the homicide, in over a quarter of these cases there were indications that one or both parties were intending to leave the relationship (n=23, 29.9%). This mostly involved the female homicide victim indicating an intention to separate from the male homicide offender (20 of the 23 cases).

In five of the 44 cases where a male homicide offender killed a female victim after separation (11.4%) family law proceedings were in progress at the time of the homicide.

Almost a quarter of males who killed their current or former intimate partners were named as respondents in Domestic Violence Orders protecting the female homicide victim at the time of the death (n=29, 24.0%). One male was named as both a protected person and respondent under a cross-Domestic Violence Order.

Males who killed female intimate partners were an average of 42 years old. Almost 20% of males who killed a female intimate partner identified as Aboriginal. Over 20% of females who were killed by a male partner identified as Aboriginal (n=27, 22.3%).

The highest number of males killed female intimate partners using sharp weapons (over 30%), and killed the female victim at the couple's shared residence (43.8%).

Almost half of all males who killed a female partner were using alcohol at the time of the homicide (n=59, 48.8%).

The most common criminal court outcome for males who killed their female intimate partners was a murder conviction (n=58, 61.1%). Over 20% of males who killed a female intimate partner killed themselves after the homicide (n=26, 21.5%).

Females who killed males

As noted above, under a fifth (18.4%) of the intimate partner homicides during the reporting period involved a female killing a male current or former intimate partner (n=28), and most of these cases involved a female victim of domestic violence killing a male Primary DV abuser (n=17, 60.7% of female perpetrated IPV homicides).

Most females killed a male partner they were currently in a relationship with (n=23, 82.1%), and of the five females who killed former partners, three killed that partner in a period less than three months after separation. In six of the 23 cases where the relationship was ongoing, there were indications that one or both parties were intending to end the relationship.

In two of the five cases where a female homicide offender killed a former male partner, family law proceedings were on foot at the time of the homicide.

A quarter of females who killed their current or former male intimate partners were protected under Domestic Violence Orders naming the male homicide victim as the respondent at the time of the homicide (n=7, 25%). Four males were named as protected persons under Domestic Violence Orders naming the female homicide offender as the respondent (14.3%). In one case the male victim was protected and named as a respondent under a cross-order.

Females who killed males in IPV homicides were an average of 34.8 years old (with a median age of 32), and almost half of the female homicide offenders identified as Aboriginal (n=13, 46.4%).

The vast majority of female homicide offenders killed the male victim by assaulting him with a sharp weapon (n=23, 82.1%). Every female perpetrated IPV homicide involved the homicide offender using a weapon to kill the male victim.

Half of the females who killed males were using alcohol at the time of the fatal episode (n=14, 50%).

The most common criminal court outcome for females who killed a male partner was a manslaughter conviction (n=20, 71.4%). One female died by suicide after killing her male partner.

IPV homicide and children

In this dataset two children were killed in addition to their mother in a homicide perpetrated by her male intimate partner.

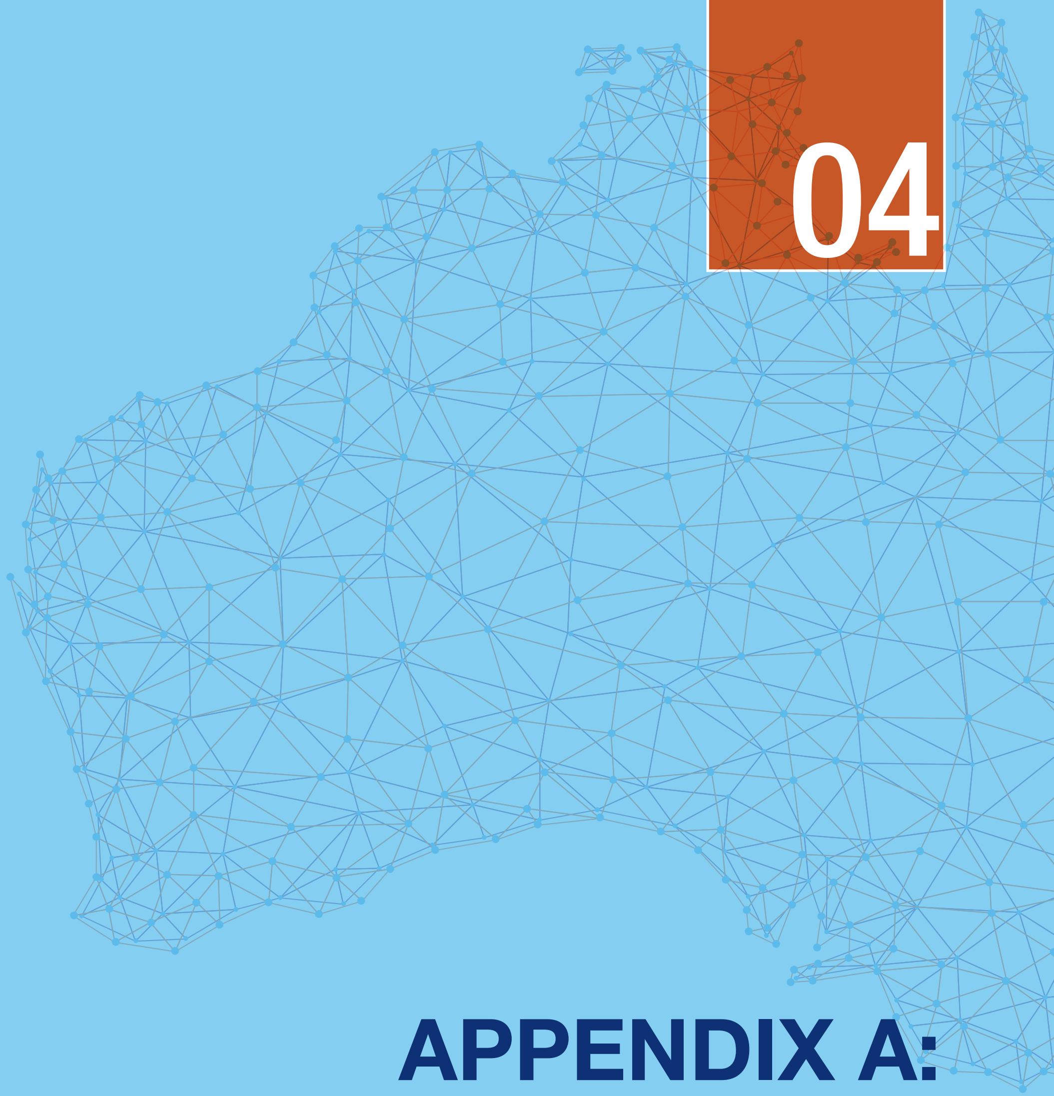
Of the 152 homicide events examined in this dataset, the Network identified at least 107 children under the age of 18 who survived the intimate partner homicide involving one, or both, of their parents.

Histories of domestic violence behaviours preceding homicides

Detailed information was available in relation to IPV homicides and histories of violence in New South Wales, Victoria, Queensland, South Australia and the Northern Territory. The data presented in this section included105 cases where male abusers killed female victims, two cases where female abusers killed male victims and two cases where male abusers killed male victims.

Of the 105 cases in which a male domestic violence primary abuser killed a female victim and the history of violence was known, most males had previously used physical violence against the female they killed (n=80, 76.2%); most had previously used emotional or psychological violence against the female they killed (n=84, 80.0%); over half had been socially abusive towards the female victim (n=64, 61.0%); and fewer were known to be sexually abusive towards the victim (n=13, 12.4%). Over a third of males who killed a female homicide victim had stalked the victim either during the relationship or after it had ended (n=38, 36.2%).

04



APPENDIX A:

Australian Domestic and Family Violence Death Review Network – Terms of Reference

Background and position summary

Domestic and family violence has a devastating impact on individuals and communities. It is a complex phenomenon and includes: child abuse; violence between siblings; violence by adolescents against parents; elder abuse; carer abuse; violence between same-sex partners; and violence perpetrated by women against their male intimate partners. However, in the overwhelming majority of cases, domestic and family violence is perpetrated by males against their female intimate partner.

Domestic and family violence can also be fatal. A significant proportion of all homicide victims are killed by a person with whom they share or have shared a domestic relationship i.e. a current or former intimate partner or family member. Women are significantly overrepresented in this category of homicide.

Domestic and family violence deaths rarely occur without warning. In many fatal cases, there have been repeated incidents of abuse prior to the homicide, as well as identifiable indicators of risk. There have typically also been many opportunities for individuals or agencies to intervene before the death. When viewed as the escalation of a predictable pattern of behaviour, domestic and family violence deaths can be seen as largely preventable.

Domestic and Family Violence Death Review Context

Background to establishment

Despite the prevalence of deaths that occur in the context of domestic and family violence, there has not, until recently, been a mechanism for the systematic review of these deaths in any Australian jurisdiction.

For well over a decade, domestic and family violence death review processes have been operational in a number of international jurisdictions, most notably in the United States where domestic violence fatality review teams were first established in the early 1990s. Since that time, domestic and family violence death reviews have also been established in Canada, the United Kingdom and New Zealand.

The broad objective of these reviews is to identify potential areas for improvement in systemic responses to domestic and family violence. Domestic and family violence death reviews operate with a view to identifying patterns and commonalities between deaths for the purposes of reform. Such processes are effective in identifying and addressing weaknesses in service delivery and systems related to domestic and family violence.

In the mid-2000s, there was a call for the establishment of domestic and family violence death review processes in Australia. Within the past five years, Victoria, Queensland, New South Wales, South Australia, Western Australia and the Northern Territory have each implemented a domestic and family violence death review function with dedicated resources. In 2015 a pilot death review process was commenced in the Australian Capital Territory.

The National Policy Context

The establishment of the Network aligns with Strategy 5.2 of the national policy agenda as detailed in *The National Plan to Reduce Violence Against Women and their Children 2010 – 2022*. This mandates States and Territories to work together to:

> ***Strategy 5.2:*** *Strengthen leadership across justice systems.*
>
> ***Action 2*** *- Drive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence.*
>
> ***Immediate national initiatives****: Monitor domestic violence-related homicide issues to inform ongoing policy development, including the Australian Institute of Criminology's National Homicide Monitoring Program to research domestic violence-related homicides, risk factors and interventions.*



Australian Domestic and Family Violence Death Review Mechanisms

Victoria

The Victorian Systemic Review of Family Violence Deaths ('VSRFVD') was established in 2009. Positioned within the Coroners Court of Victoria and operating under the provisions of the *Coroners Act 2008* (Vic), the VSRFVD assists with open coronial investigations of family violence-related deaths involving children and adults.

The VSRFVD has five main aims, which are to:

- Examine deaths suspected to have resulted from family violence;
- Identify risk and contributory factors associated with deaths resulting from family violence;
- Identify trends and patterns in deaths resulting from family violence;
- Identify trends and patterns in responses to family violence; and
- Provide coroners with information obtained through the exercise of the above functions.

The VSRFVD's definitions of 'family violence' and a 'family member' are aligned with the *Family Violence Protection Act 2008* (Vic) and the *Victorian Indigenous Family Violence Taskforce Report* (2003).

New South Wales

On 16 July 2010, following recommendations made in 2009 by the Domestic Homicide Advisory Panel, the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* (NSW) commenced, amending the *Coroners Act 2009* (NSW) by inserting Chapter 9A and thereby establishing the Domestic Violence Death Review Team ('the DVDRT').

The DVDRT is convened by the NSW State Coroner and is constituted by representatives from key government stakeholders, including law enforcement, justice, health and social services, as well as four representatives from non-government agencies.

The core legislative functions of the DVDRT are to:

- Review and analyse individual closed cases of domestic violence deaths (as defined in the *Coroners Act 2009*);
- Establish and maintain a database so as to identify patterns and trends relating to such deaths; and
- Develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

The DVDRT reports annually to the NSW Parliament.

Queensland

The Domestic and Family Violence Death Review Unit ('DFVDRU') was established in the Coroner's Court of Queensland in January 2011 and provides assistance to coroners investigating domestic and family violence related deaths under the *Coroners Act 2003* (Qld) with a view to ensuring the investigation examines the context in which the death occurred and identifies systemic shortcomings and opportunities to prevent future deaths. The DFVDRU assists coroners to formulate preventive recommendations for those investigations that proceed to inquest.

The DFVDRU undertakes research in relation to domestic and family violence, which can be used to contextualise and inform coronial findings and recommendations. The DFVDRU also maintains a dataset of domestic and family violence related homicides and suicides.

The DFVDRU's definitions align with the *Domestic and Family Violence Protection Act 2012* (Qld).
In 2015, with the establishment of an independent Domestic and Family Violence Death Review and Advisory Board, designed to enhance the systemic review of these types of deaths, the DFVDRU is now also responsible for the provision of administrative, secretariat and research support to the Board.

South Australia

In response to election commitments made by the South Australian Government, the Office for Women and the South Australian Coroner's Court have

undertaken a partnership to research and investigate domestic violence related deaths. The position of Senior Research Officer (Domestic Violence) was established in January 2011 as an initiative of the South Australian *A Right to Safety* ('ARTS') reform agenda.

This position works collaboratively with the ARTS reporting and advisory structure and reports on outcomes to the Chief Executive Group (chaired by the Minister for the Status of Women) which oversees ARTS outcomes.

The position is based within the South Australian Coroner's Office and works as part of the Coronial investigation team to:

- identify deaths with a domestic violence context in order to assist in the investigation of the adequacy of system responses and/or inter-agency approaches which may prevent deaths occurring within that context;
- review files, provide interim reports and have specific input into Coronial Inquests which relate to domestic violence;
- develop data collection systems in order to inform Coronial processes and identify demographic or service trends, gaps or improvements more broadly; and
- conduct specific retrospective research projects relevant to building a domestic violence death review evidence base.

The legislative basis for this position sits within the *Coroners Act 2003* (SA). The definition of 'domestic violence context' is aligned with the *Intervention Orders (Prevention of Abuse) Act 2009* (SA).

Western Australia

On 1 July 2012, the Ombudsman commenced a new role to review family and domestic violence fatalities. For the purposes of this jurisdiction, a family or domestic relationship has the same meaning as given to it under section 4 of the *Restraining Orders Act 1997* (WA).

The Ombudsman has a number of functions in relation to the review of family and domestic violence fatalities:

- reviewing the circumstances in which and why family and domestic violence deaths occur;
- identifying patterns and trends that arise from reviews of family and domestic violence deaths; and
- making recommendations to public authorities about ways to prevent or reduce family and domestic violence deaths.

The Ombudsman reports comprehensively on family and domestic fatalities.

Northern Territory

The Northern Territory recently allocated permanent resourcing for the position of Research Officer (Family Violence) based within the Northern Territory Coroner's Office.

The position operates under the provisions of the *Coroners Act 1993* (NT) to assist open coronial investigations of domestic and family violence related deaths by examining the context in which the death occurred and the adequacy of system responses to domestic and family violence to inform coronial findings and recommendations.

The position also maintains an evidence base so as to identify patterns and trends from reviews of family and domestic violence deaths. Currently that dataset is limited to intimate partner domestic violence related deaths, but it is intended that the data collection will also extend to include other familial relationships where the death has been identified as domestic and family violence related.

Common Elements of Review Teams

The following are common elements across all existing Australian domestic and family violence death review mechanisms:

- each is underpinned by the view that domestic and family violence-related deaths are largely preventable;
- each operates in accordance with State-based legislation and state determined governance structure;



- each State clearly defines relationships and behaviours that amount to domestic and family violence;
- each adopts review criteria which facilitate the review of homicides, homicide/suicides and suicides where such deaths have occurred in a context of domestic and family violence; and
- each reviews individual deaths with a domestic violence context as well as identifying data trends and patterns across multiple deaths.

ADFVDR Network Overview

Following the implementation of domestic and family violence death review mechanisms in several Australian jurisdictions in recent years, the Australian Domestic and Family Violence Death Review Network ('the Network') was established in March 2011. The Network comprises permanent representatives from each of the established Australian death review teams, namely the:

- Victorian Systemic Review of Family Violence Deaths (Vic);
- Domestic Violence Death Review Team (NSW);
- Domestic and Family Violence Death Review Unit (Qld);
- Domestic Violence Unit (SA);
- Reviews Team (WA); and
- Family Violence Death Review Unit (NT).

The Network recognises that Tasmania and the Australian Capital Territory are exploring, or trialling, the implementation of a death review mechanism within their respective jurisdiction; and as such have not consolidated a final model of operating.

Representatives of these jurisdictions are also considered standing members of the Network where such a trial is being undertaken.

Special Observer Membership of the ADFVDRN

Special observers are invited to participate in discussions and Network processes but do not have decision-making authority. The addition of Special Observers recognises that domestic and family violence death review processes are established and operational outside of Australia and can contribute to the knowledge and development of the work undertaken by the ADFVDRN.

Special Observer Members

New Zealand

New Zealand's Family Violence Death Review Committee (FVDRC) was established in 2008 following a recommendation by the *Taskforce for Action on Violence within Families*, and support from the family violence sector. In April 2011, following amendments to the *New Zealand Public Health and Disability Act 2000* ('the Act'), the Committee became the responsibility of the Health Quality & Safety Commission ('HQSC'). The Committee is located in the Commission and operates in close collaboration with the Ministries of Health, Justice and Social Development, the New Zealand Police, and other key government and community agencies. The Committee operates under the Act and is accountable to the Commission.

The FVDRC's functions are to:

- review and report on family violence deaths, with a view to reducing the numbers of deaths and to continuous quality improvement through the promotion of ongoing quality assurance programs;
- develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality and are relevant to the Committee's functions; and
- advise on any other matters related to family violence deaths that the HQSC specifies.

In order to fulfill these functions, the FVDRC collects data on family violence deaths, reviews selected deaths via a multi-sectoral review process, identifies trends and patterns over time and makes local and national recommendations.

Purpose

The overarching goals of the Network are to:

- improve knowledge regarding the frequency, nature and determinants of domestic and family violence deaths;
- identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths;
- identify, collect, analyse and report data on domestic and family violence-related deaths;
- analyse and compare domestic and family violence-related deaths; and
- analyse and compare domestic and family violence death review findings and recommendations.

Scope

The Scope of the activities of the Network includes:

- using the learning and outcomes of State-based review processes to benefit the work of other Network members. This shall include comparing and reporting on findings across jurisdictions;
- defining minimum case inclusion criteria and developing standardised minimum data sets across each jurisdiction to contribute to the development of minimum standard national data in relation to domestic and family violence-related deaths; and
- sharing information and evidence relating to the identification of domestic and family violence risk indicators and/or case characteristics.

Some key areas of consideration may include:

- identifying common risk indicators, case characteristics and/or system failures in the lead-up to a death; and
- the development of policies and recommendations to State and Federal government.

Governance

Membership

- Membership consists of persons or agreed representatives from each State-based domestic and family violence death review.
- Membership is closed and new membership and special observer requests will be determined by standing members of the Network, based on the compatibility of the function or unit with the purpose of the Network.
- Membership decisions will be formally documented and relayed to the requesting person or authority in writing by the Chairperson.
- Network meetings are restricted to Network members, officially recognised special observers and, by agreement, invited guests.
- The Network can, by agreement, request advice, support and/or consult with outside agencies or individuals as required.

Confidentiality Provisions

- Maintaining confidentiality is critical to the functioning of the Network. Due to the sensitive nature of the information discussed, information discussed in the Network is confidential and non-disclosure requirements apply.
- Where the State-based death review is involved in reviewing open coronial matters there will be specific legislative confidentiality provisions required of each participant. It is the responsibility of individual members to be aware of and adhere to their particular legislative requirements regarding confidentiality.

Decision making

- Each Member State is responsible for making decisions in line with their employment and legislative responsibilities. This includes seeking appropriate permission, advice and authority to advance information or participate in decision-making where necessary.



- The Network operates within a consensus decision making framework, which recognises the autonomy, and differing operating models, of each jurisdiction.
- As an underlying principle, this model will focus on identifying, and as much as practicable, addressing any individual Member's concerns to achieve the agreement of all jurisdictions.
- Where full agreement cannot be achieved on a particular course of action by the Network, but majority consensus has been reached, than this will be documented, but will not restrict the Network from undertaking a particular course of action.
- The Chairperson will document all decisions and actions arising from each Network meeting.

Meeting Frequency

- Meetings will be held, either by teleconference or face-to-face, at least four times per year. Meetings may occur more frequently as determined by the needs of the Network.

Roles and Responsibilities

Members

- All members are responsible for seeking relevant permissions, advice or authority before participating in decision-making and agree to adhere to the statutory or legislative requirements of their role.
- All members agree to contribute and cooperate in good faith and declare any conflict of interest or other disclaimers at the first possible opportunity or realisation of that conflict.
- All members may submit agenda items and papers for consideration by the Network and should endeavour to do so in a timely fashion for inclusion in the meeting agenda.
- Each member is responsible for keeping their own records of discussion from meetings.

Chairperson

The position of Chairperson will rotate between members on an annual basis. Appointment of the Chairperson will be by agreement of the Network members at the end of each calendar year and should not be undertaken in consecutive years by any representative from the same State.

The roles and responsibilities of the Chairperson include:

- preparing and disseminating the meeting agenda and relevant documents in a timely manner;
- ensuring the Network operates in a manner consist and in alignment with the Terms of Reference;
- moderating decision-making processes;
- minuting all decisions and actions arising from each meeting and distribution of these minutes to members as soon as practicable after the conclusion of each meeting;
- maintaining a history of all documents produced as part of the Network and transferring that catalogue of information to the next nominated Chairperson; and
- with prior agreement by the Network, distributing information about the Network, making comment on Network matters (as appropriate), responding to enquiries and correspondence, requests for membership or meeting attendance and other such matters.

Last updated April 2018

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APPENDIX B:

Australian Domestic and Family Violence Death Review Network – Domestic and Family Violence Homicide Consensus Statement



Background and Purpose

Following the implementation of domestic and family violence death review mechanisms in several Australian jurisdictions, the Australian Domestic and Family Violence Death Review Network ('the Network') was established in March 2011. The Network comprises representatives from each of the established Australian death review teams, namely:

- Domestic Violence Death Review Team (New South Wales);
- Domestic and Family Violence Death Review Unit (Queensland);
- Domestic and Family Violence Death Review (South Australia);
- Victorian Systemic Review of Family Violence Deaths;
- Review Team Ombudsman Western Australia; and
- Family Violence Death Review Unit (Northern Territory).

The overarching goals of the Network are to, at a national level:

- improve knowledge regarding the frequency, nature and determinants of domestic and family violence deaths;
- identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths;
- identify, collect, analyse and report data on domestic and family violence-related deaths; and
- analyse and compare domestic and family violence death review findings and recommendations.

These goals align with the *National Plan to Reduce Violence Against Women and their Children 2010-2022*.

Definitions

This Consensus Statement defines the inclusion criteria adopted by the Network for domestic and family violence homicide. While there is no universally agreed definition of the behaviours that comprise domestic and family violence, in Australia it includes a spectrum of physical and non-physical abuse within an intimate or family relationship. Domestic and family violence behaviours include physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation, and economic deprivation. Primarily, domestic and family violence is predicated upon inequitable relationship dynamics in which one person exerts power and coercive control over another. This accords with the definition of family violence contained in *the Family Law Act 1975* (Cth), which is adopted by the Network.

The definition of 'homicide' adopted by the Network is broader than the legal definition of the term. 'Homicide', as used by the Network, includes all circumstances in which an individual's intentional act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law.

Surveillance

The World Health Organization defines surveillance as:

> … systematic ongoing collection, collation and analysis of data and the timely dissemination of information to those who need to know so that action can be taken.[1]

Surveillance processes produce data that describe the frequency and nature of mortality and morbidity at the population level. This serves as a first step to the identification of risk factors to target preventive intervention. The Network applies these principles to ensure a consistent and standardised approach to data collection and analysis. To identify the target population and opportunities for intervention, surveillance of domestic and family violence homicide incidents is conducted both retrospectively and prospectively.

1 Adopting the definition in J.M Last (ed), *A Dictionary of Epidemiology* (Oxford University Press, 4th ed, 2001).

Categorisation

Identification and classification of domestic and family violence deaths is complex and needs to be conducted cautiously. The key considerations in this area are:

I. the case type;

II. the role of human purpose in the event resulting in a death (intent);

III. the relationship between the parties (i.e. the deceased-offender relationship); and

IV. the domestic and family violence context (i.e. whether or not the homicide occurred in a context of domestic and family violence).

Consideration 1: Case Type

Determination of case type (i.e. external cause, natural cause, unknown cause) is the first consideration for classification. An external cause death is any death caused, directly or indirectly, by an offender through the application of assaultive force or by criminal negligence. In cases where the cause of death is unknown, the death is monitored until further information is available.

Case Type	Definition	Inclusion
External Cause	Any death resulting directly or indirectly from environmental events or circumstances that cause injury, poisoning and / or other adverse effect.	Yes
Unexplained Cause	Deaths for which it is unable to be determined whether it was an external or natural cause.	No
Natural Cause	Any death due to underlying natural causes. Includes chronic illness due to long-term alcohol abuse / smoking.	No



Consideration 2: Intent

The second consideration is to establish the role of human purpose in the event resulting in the external cause death. In accordance with the WHO International Classification of Disease (ICD-10), the intent is coded according to the following categories.

Intent	Definition	Inclusion
Assault*	Injury from an act of violence where physical force by one or more persons is used with the intent of causing harm, injury, or death to another person; or an intentional poisoning by another person. This category includes intended and unintended victims of violent acts (e.g. innocent bystanders).	Yes
Complications of Medical or Surgical Care	Death which occurred due to medical misadventure, accidents or reactions in the administration of medical or surgical care drugs or medication.	No
Intentional Self-Harm	Injury or poisoning resulting from a deliberate violent act inflicted on oneself with the intent to take one's own life or with the intent to harm oneself.	No
Legal Intervention/ Operations of War	Death which occurred due to injuries that were inflicted by police or other law-enforcing agents (including military on duty), in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order or other legal action.	Yes (only where DV context present)
Still Enquiring	Death under investigation whereby the intent or case type is not immediately clear based on the level of information available.	No
Undetermined Intent	Events where available information is insufficient to enable a person to make a distinction between unintentional, intentional self-harm and assault.	No
Unintentional	Injury or poisoning that is not inflicted by deliberate means (that is, not on purpose). This category includes those injuries and poisonings described as unintended or "accidental", regardless of whether the injury was inflicted by oneself or by another person.	No
Unlikely to be Known	Upon case completion, the coroner was unable to determine whether the death was due to Natural or External causes, therefore unable to make a determination on intent.	No

* Mortality classification systems refer to 'homicide' as 'assault'.

Consideration 3: Relationship

The third consideration for classification is whether a domestic or familial relationship existed between the deceased and the offender. The Network recognises the various state and federal legislative instruments that define and address deceased-offender relationship. In particular, it is acknowledged that the member jurisdictions operate within the following legislative frameworks:

- *Coroners Act 2009* (NSW);
- *Domestic and Family Violence Protection Act 2012* (Qld);
- *Family Violence Protection Act 2008* (Vic);
- *Intervention Orders (Prevention of Abuse) Act 2009* (SA);
- *Restraining Orders Act 1997* (WA) *and Parliamentary Commissioner Act 1971* (WA); and
- *Domestic and Family Violence Act 2007* (NT).

Each review team recognizes current or former intimate partners (heterosexual and homosexual), family members (adults and children), and kin, as relevant relationships. To standardise the inclusion and categorisation of relationship type, the following definitions are adopted by the Network.

Relationship Type	Definition	Inclusion
Intimate**	Individuals who are or have been in an intimate relationship (sexual or non-sexual).	Yes
Relative***	Individuals, including children, related by blood, a domestic partnership or adoption.	Yes
Aboriginal and/or Torres Strait Islander kinship relationships	A person who under Aboriginal and/or Torres Strait Islander culture is considered the person's kin.	Yes
No relationship	There is no intimate or familial relationship between the individuals.	Yes (only where DV context present)
Unknown	Relationship is unknown.	No

** This includes current and former intimate relationships irrespective of the gender of the individuals.

*** This includes formal and informal family-like relationships, and explicitly includes extended family-like relationships that are recognised within that individual's cultural group.



Consideration 4: Domestic and Family Violence Context

Having determined that a homicide has occurred and that a domestic relationship exists between the deceased and offender, the final consideration for classification is whether the homicide occurred in a domestic or family violence context. Deaths that fulfil these criteria are defined as domestic and family violence homicides and are subject to review by each jurisdiction.

Each jurisdiction can also review deaths where no direct domestic relationship exists between the deceased and offender but the death nonetheless occurs in a context of domestic and family violence. For example, this might include a bystander who is killed intervening in a domestic dispute or a new partner killed by their current partner's former abusive spouse.

Similarly, the Network recognises that the existence of an intimate or familial relationship between a deceased and offender does not, in itself, constitute a domestic and family violence homicide. In these deaths, other situational factors determine the fatal incident, such as the offender experiencing an acute mental health episode. These deaths do not feature many of the characteristics known to define domestic and family violence, such as controlling, threatening or coercive behaviour; having previously caused the other person to feel fear; or evidence of past physical, sexual or other abuse.

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APPENDIX C:

Australian Domestic and Family Violence Death Review Network – Data Sharing Protocols



Purpose

The purpose of this document is to establish governance arrangements to allow for the sharing of data across jurisdictions to support the establishment of a National Minimum Dataset on domestic and family violence deaths.

It briefly discusses the policy landscape and national impetus for the development of a dataset, recognises the different governance processes within each jurisdiction that allows this data to be shared and establishes specifications for which all jurisdictions that participate within this process agree to adhere to, for the purposes of appropriate data collection, storage and dissemination.

Background

For well over a decade, domestic and family violence death review processes have been operational in a number of international jurisdictions, most notably in the United States where domestic violence fatality review teams were first established in the early 1990s.

Since that time, domestic and family violence death reviews have also been established in Canada, the United Kingdom, Australia and New Zealand, as well as in other jurisdictions.

The broad objective of these reviews is to identify potential areas for improvement in systemic responses to domestic and family violence. Domestic and family violence death reviews operate with a view to identifying patterns and commonalities between deaths for the purposes of reform. Such processes are effective in identifying weaknesses in service delivery and systems, and opportunities to improve responses to domestic and family violence across the service system.

In the mid-2000s, after a long period of sector advocacy, there was a call for the establishment of domestic and family violence death review processes in Australia. Within the past decade, Victoria, Queensland, New South Wales, South Australia, Western Australia and the Northern Territory have each implemented a domestic and family violence death review function with dedicated, permanent, resources.

In 2015 a pilot death review process was commenced in the Australian Capital Territory and Tasmania is currently undertaking a scoping exercise within their coronial jurisdiction to enhance the identification and review of these types of deaths.

Following the implementation of domestic and family violence death review mechanisms in several Australian jurisdictions, the Australian Domestic and Family Violence Death Review Network ('the Network') was established in March 2011. The establishment of the Network aligned with Strategy 5.2 of the national policy agenda as detailed in *The National Plan to Reduce Violence against Women and their Children 2010 – 2022* ('the National Plan').

As detailed in Action 19 of the Second Action Plan one of the overarching goals of the Network is to identify, collect, analyse and report data on domestic and family violence related deaths, and share information, for the purposes of improving knowledge regarding these types of deaths.

To achieve this work, the Network has taken a number of steps to be able to comprehensively report these data at a national level.

This has included the establishment of a nationally consistent definition of a 'domestic and family violence homicide', through the Homicide Consensus Statement which defines the inclusion criteria adopted by all members of the Network for implementation within their respective jurisdictional review mechanisms.

The Consensus Statement sets out the processes for identifying and classifying domestic and family violence homicides, taking into consideration the case type, the intent, the relationship between the deceased and the offender, and the domestic and family violence context of the death.

Further, building upon this standardised definition, the Network has also established Data Collection Protocols to develop a staged, standardised, national dataset for domestic violence homicides, with the intent to ultimately extend data collection to include homicides within a family relationship, 'bystander' homicides, and suicides that have been identified as domestic and family violence related.

To accommodate jurisdictional differences and mandates that govern the way in which the death review processes are conducted, this preliminary data collection covers all closed intimate partner domestic

violence context homicides from 2008 onwards to allow for consistency in reporting across jurisdictions.

This dataset identifies specific data variables for collation which include: homicide details; demographic details, and other characteristics for the deceased and offender; case characteristics; histories of violence; and relationship characteristics between the deceased and the offender.

Jurisdictional Covernance

With the majority of domestic and family violence death review mechanisms in Australia embedded within coronial jurisdictions, this paper recognises the legislative landscape which governs the management of data and information in relation to these types of deaths in each state or territory.

Each jurisdiction currently has processes in place to allow for the collection of data and information in relation to domestic and family violence deaths, which includes strict provisions as to when, how and why this information may be shared.

Queensland

In Queensland, data and information pertaining to domestic and family violence deaths is generated through a two-tiered review process, either through supporting Coroners in their investigation of a relevant reportable death (Tier 1) or through the Domestic and Family Violence Death Review and Advisory Board, who are responsible for the systemic review of these types of deaths (Tier 2).

Under the *Coroners Act 2003* (Qld) the State Coroner is responsible for approving the release of any data or information held in relation to the coronial jurisdiction. The Act specifies when and how this information may be shared, and what the State Coroner needs to consider when making a determination to release data or information gathered as part of a coronial investigation.

Applicable provisions also allow for the State Coroner to specify how long a person may have access to coronial information and also provides for the State Coroner to withdraw their consent for access.

The Act further specifies that access to investigation documents must be de-identified except if the State Coroner is satisfied that the opportunity for increased knowledge that may result from the research outweighs the need to protect the privacy of any living or dead person.

While this Act mainly pertains to investigation documents generated through a coronial investigation, the principles outlined within the Act are extended to apply to data and information generated through the death review process as part of the coronial investigation.

In accordance with s 91ZA(1) the Board may enter into an arrangement with a corresponding entity about sharing of information held by the Board or the corresponding agency, as long as it cannot be seen to prejudice a coronial investigation or criminal proceedings. They must also consult with the State Coroner, who is Chair of the Board, about the proposed disclosure if it pertains to coronial information.

Data in relation to these types is stored within a secure server, with access restricted to staff at the Coroners Court who are bound by relevant confidentiality requirements to ensure the safe storage of this type of information.

New South Wales

In New South Wales, data and information pertaining to domestic violence deaths is collected by the Domestic Violence Death Review Team (DVDRT) Secretariat and housed in a purpose built secure database. The Team is convened by the NSW State Coroner.

The Team was established with the insertion of Chapter 9A of the *Coroners Act 2009* (NSW) and information sharing is governed by a number of sections within this Chapter. Under s101F(4) *'the Convenor may enter into an agreement or other arrangement for the exchange of information between the Team and a person or body having functions in another state or territory that are substantially similar to the functions of the Team, being information relevant to the exercise of the functions of the Team or that person or body.'*



Information sharing is also anticipated under s101M of the Act, which provides exceptions to the strict confidentiality provisions governing the Team's operation and allows the Convenor to share the Team's data and information pursuant to an agreement or arrangement made under the Chapter.

South Australia

In South Australia, data and information relating to domestic and family violence deaths is gathered through the coronial investigation of a relevant reportable death. The Senior Research Officer (Domestic Violence) supports the Coroner to investigate deaths and produces detailed reports and analysis on all homicide deaths with a domestic violence context.

As well as informing the active coronial investigation, specific data and information, relating to South Australian homicides and suicides, is collected in the Coronial Domestic Violence Information System (CDVIS). The CDVIS is a purpose built secure database used to house data and produce reports relating to the prevalence and context of homicides in South Australia. This data is reported in the State Coroner's Annual Report.

The Coroners Act 2003 (SA), under s 38, provides discretion for the State Coroner, for the purposes of research, education, public policy development or for any other sociological purpose,
to permit a person or body access and use of information derived from records of the Coroner's Court. Furthermore, the provision of this information may be subject to such conditions as the State Coroner thinks fit.

Victoria

In Victoria, data and information pertaining to family violence deaths is collected by the Victorian Systemic Review of Family Violence Deaths (VSRFVD) of the Coroners Court of Victoria. The VSRFVD is led by the State Coroner.

The Coroners Court of Victoria maintains a secure purpose built Surveillance Database of all reviewable and reportable deaths in Victoria. The Victorian Coroners Court's Victorian Homicide Register was established to draw from this database as the basis for the identification and collection of VSRFVD data.

Section 115(2) of the *Coroners Act 2008* (Vic) provides that a Coroner may release a document to:

I. an interested party if the coroner is satisfied that the party has a sufficient interest in the document

II. a statutory body if the Coroner is satisfied that the release of the document is required to allow the statutory body to exercise a statutory function

III. a police officer for law enforcement purposes

IV. a person who is conducting research if the Coroner is satisfied that the research has been approved by an appropriate human research ethics committee

V. any person if the Coroner is satisfied that the release is in the public interest

VI. a person specified in the rules as being a person to whom documents may be released.

The Coroners Act 2008 (Vic.) also provides that a Coroner may impose conditions on the release of any document. Penalties apply if a person to whom a document has been released fails to comply with any condition placed on that release.

Western Australia

The Ombudsman commenced an important role to review all family and domestic violence fatalities on 1 July 2012.

In doing so, the Ombudsman has all the powers provided for in the *Parliamentary Commissioner Act 1971* (WA) (the Act) and all of the powers of a standing Royal Commission. In addition to information relating to the Ombudsman's role to review family and domestic violence fatalities, significant information, data, collation and analysis regarding family and domestic violence arising from reviews undertaken is reported annually to Parliament.

The Ombudsman also undertakes major investigations of his own-motion in relation to family and domestic

violence fatalities. The first major own motion investigation, *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, was tabled in Parliament in November 2015. The report of the investigation contains extensive reporting and analysis of data and information regarding family and domestic violence fatalities in Western Australia and 54 recommendations to prevent or reduce family and domestic violence fatalities.

The Ombudsman also undertakes reporting of the steps taken to give effect to the recommendations arising from major own motion investigations. A report on giving effect to the recommendations arising from the *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* was tabled in Parliament in November 2016.

Furthermore, subject to the relevant provisions of s23(1b) of the Act, the Ombudsman may disclose information, or make a statement, to any person or to the public or a section of the public if, in his opinion, it is in the interests of any department or authority to which the Act applies or of any person, or is otherwise in the public interest.

Northern Territory

In the Northern Territory, data and information relating to domestic and family violence deaths is gathered through the coronial investigation of a relevant reportable death.

As well as informing the active coronial investigation, specific data and information relating to domestic and family violence related homicides is collected in the Northern Territory coronial database which has restricted access.

There is no express provision in the *Coroners Act 1993* (NT) that provides for the release or sharing of any data or information held in relation to coronial investigations.

However, in line with the overarching goal of the Network to collect, analyse and report on domestic and family violence related deaths at a national level, the Northern Territory agrees to provide such data required for the purposes of achieving its goal including for the development of the national minimum dataset.

All Northern Territory data is de-identified to ensure the protection of the privacy of individuals involved in coronial investigations.

Issues

Systemic monitoring and surveillance of relevant reportable death categories are a core component of any death review mechanism.

While they are a necessary first step in identifying cases that may benefit from a more detailed review, they also assist in developing an understanding of the prevalence and incidence of these types of deaths within any locality or jurisdiction. They may further assist in the identification of risk indicators or cohorts who may be at increased risk of harm, which enables a more targeted approach to prevention activities.

Despite the prevalence of deaths that occur in the context of domestic and family violence, there has not, until recently, been a mechanism for the systematic review of these deaths across all Australian jurisdictions.

Limitations with current processes for the collection of homicide data have been identified in a range of national reports. For example, the Australian Institute of Criminology have recently highlighted that qualitative incident specific analysis is required to understand the nuances of precipitating events, personal characteristics of offenders and victims, and motives of perpetrators pertaining to domestic and family violence homicides.[1]

This is not achievable through existing national data collection mechanisms.

The Australian Human Rights Commission[2] have further identified that there is a lack of reliable reporting, in line with consistent definitions of domestic and family violence homicides. In particular, it was noted that the National Homicide Monitoring Program (NHMP) does not report on the context of domestic violence limiting the ability of this function to report on the nuances of this type of death.

1 T. Cussen and W. Bryant, Domestic/Family Homicide in Australia (Australian Institute of Criminology, Canberra, 2015).
2 Australian Human Rights Commission, A National System for Domestic and Family Violence Death Review, Sydney, 2017, p. 50.



Likewise, the National Coronial Investigation System (NCIS) does not reliably report on the context of how a person has died, focusing on the medical cause of death. As a data storage system for coronial information, the NCIS is not a system that is designed to support more nuanced analysis of these types of deaths.

While combining data generated through the death review process is not research in and of itself, there are key learnings that can be adopted from established research guidelines which can inform the consideration of how to administratively manage and share such information, including from the *Australian Code for the Responsible Conduct of Research* (the Code).

The Code promotes integrity in research, and describes the principles and practices for encouraging the responsible conduct of research for administrators, institutions and researchers. Applicable to this initiative they highlight areas for consideration by institutions for the management of data, and the publication and dissemination of research findings that have been used to inform the development of these protocols for the sharing of data across jurisdictions.

Notably, upon review of these guidelines, the legislative basis within which all of our respective death review mechanisms operate and the existing jurisdictional mechanisms for the storage and retention of data and information generated through the review process, already supersede processes that are put in place to guide the conduct of responsible research.

In this regard, it is acknowledged at the outset that all Members are required to comply with any governing legislation, policies and procedures applicable to their jurisdiction for the appropriate collation, storage and dissemination of data generated through their respective death review processes.

While individual processes may vary across jurisdictions, these protocols aim to instead establish a national standard for the storage, ownership and dissemination for data to be shared across jurisdictions for the sole purpose of the development of a national database on domestic and family violence related deaths; with the ultimate aim of preventing future deaths.

Shared Specifications

All data and information provided to inform the development of a national picture of domestic homicides is strictly confidential and will be treated as such; until such point as all Members have formally agreed to its release.

While jurisdictions are empowered under their own legislative framework to manage their data as they consider it appropriate to do so, the following points apply to the custodianship and management of data provided by other jurisdictions to inform this initiative.

Data storage

Each Member must take all necessary steps to ensure that data provided by any other Member for the purposes of informing a national picture of domestic and family violence homicides is secure at all times.

This must include, but not be limited to, storage on a secure server with access restricted to Members hosting the data storage.

As a general principle, where such data is transmitted electronically, this should only be communicated by means of a formal government department, agency or authority email, or encrypted data storage device and password protected. The password should be communicated and stored separately to this communication.

Data will be provided in a de-identified format only. This includes the removal of the following: name of offender, name of deceased, address of death[3], and identifying details pertaining to the specific circumstances of the death.

3 Recognising the specific vulnerabilities associated with people residing in rural and remote location, or challenges associated with different service systems in these areas, members may need to consider a way to standardise and code this information across jurisdictions to allow for appropriate analysis, while retaining privacy and confidentiality of individual cases.

Data ownership

Data is provided by Members for the purposes of improving knowledge regarding the frequency, nature and determinants of these types of deaths; and as such data cannot be used for any other purpose without the express permission of each contributing Member.

Members retain all intellectual property rights and permissions to data that they have provided; including the right to withdraw their consent for this data and information to be stored or accessed by other Members.

Should they make a determination to do so, Member jurisdictions must advise the Network in writing that they withdraw their consent for this data and information to be accessed. In this event, every other jurisdiction must, as soon as practicable, take all steps necessary to permanently delete or destroy any information or data held by them that had been provided by the requesting jurisdiction. They must then confirm to the requesting jurisdiction that this has been completed in writing.

The exception to this specification are documents that are within the public domain, and that the requesting jurisdiction has previously provided consent to release publicly.

Ownership of the contributed data remains the property of the individual contributing Member. As such each Member must be consulted with, and agree to, the use of their data for inclusion in any project, document or report, or through presentation in any forum.

In the event that a Member makes a determination that their data and information should not be included within any report or activity undertaken by the Member, then this should not restrict other Members from participating within this activity or report. It is preferable to note within any documentation produced by the Members, that the report does not reflect the full membership of the Network.

Data dissemination

Members are expressly prohibited from referencing, or releasing, any data or information provided by another Member without their express written consent.

Members commit to taking all reasonable steps to ensure that any data or findings are accurate and properly reported. Should Members become aware of misleading or inaccurate statements about the data they have contributed they must take action to correct this as soon as practicable, including to notify the Network chair as soon as possible.

Review

This document will be reviewed annually to ensure it accords with the Network's priorities, and can be reviewed at any time as requested by a participating jurisdiction.

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AUSTRALIAN DOMESTIC AND FAMILY VIOLENCE DEATH REVIEW NETWORK

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